GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Medicaid/PeachCare for Kids®

Provider Billing Manual
CMS-1500

Version 1.30

Table of Contents

1 Introduction

1.1 Medicaid Overview

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments, including the District of Columbia and the Territories, to assist States in furnishing medical assistance to eligible needy persons. **Title XXI** of the Social Security Act PeachCare for Kids® Program (PeachCare) was passed during the 1998 session of the Georgia General Assembly. Together, Medicaid/PeachCare for Kids® provides the largest source of funding for medical and health-related services for individuals with low income and resources.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State:

- Establishes its own eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets the rate of payment for services
- Administers its own program

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, Medicaid eligibility and/or services within a State can change during the year.

The Department of Community Health (DCH) is managed by a nine-member board appointed by the Governor, and the Division of Medical Assistance (the Division) within DCH, administers Medicaid/PeachCare for Kids®. (O.C.G.A.§§31-5A-1 *et seq.*). Service delivery is accomplished through a variety of relationships with private and public entities and reimbursement is coordinated through DCH's third party administrator Fiscal Agent, Gainwell Technologies.

1.2 Gainwell Technologies in the State of Georgia

Effective November 1, 2010, Gainwell Technologies will provide an efficient transition of fiscal agent responsibilities and a smooth transition from the current Georgia Medicaid Management Information System (GAMMIS) to the new GAMMIS interChange. InterChange is a Gainwell Technologies-developed GAMMIS that has been developed over years of successful implementations. InterChange is a Centers for Medicare and Medicaid Services (CMS)-certifiable, highly sophisticated, feature-rich system centered on a strong, Medicaid-specific relational data model. This design and supporting architecture deliver enhanced flexibility, scalability, and reliability.

1.3 Overview of Functions

DCH

Function:

Administration

Budget and Fiscal Control

Contract Administration and Monitoring

Program Policies and Procedures

Liaison with Federal Agencies

Facility Licensing Office of Regulatory Services (ORS)

Gainwell Technologies

Function:

Fee for Service (FFS) Claims Processing

Encounter Processing

Provider/Member Enrollment

Provider/Member Contact Center/Written Inquiries

Provider Training

Third Party Liability (TPL)

Financing and Banking

Enrollment for PeachCare

Function:

Enrollment for kids

Eligibility Determination

GMCF

Function:

Pre-Certification

Medical- Prior Approval (PA)

Outlier Review

Out-of-State Services

Pre-Payment Review

Georgia Families

Function:

CMO Member Enrollment

DHS/DFCS/SSA

Function:

Eligibility Determination

Prior Approval

2 Purpose

2.1 Overview

The CMS-1500 Billing Manual was created to help providers accurately complete and file a Medicaid/PeachCare for Kids® CMS-1500 claim form. This manual assists you by offering billing instructions, sample CMS-1500 forms, and contact information for services beyond the scope of this manual.

2.2 The Purpose of this Manual

This manual contains basic billing information concerning Georgia's Medicaid/PeachCare for Kids® program and is intended for use by all participating providers. This manual encompasses the terms and conditions for receipt of reimbursement.

We urge you and your office team to familiarize yourself with the contents of this manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning eligibility and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

This manual should be used in conjunction with the following Georgia Medicaid policy manuals:

- Part I Policies and Procedures for Medicaid/PeachCare for Kids® which contains basic information concerning the Georgia Medicaid Program along with the terms and conditions for receipt of reimbursement.

- Part II Policies and Procedures specific to the services you provide. This manual explains covered services, their limitations, and who is eligible to receive the service.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and Department of Community Health (the Department), Medicaid Division. When such amendments are made, they will be posted at the Gainwell Technologies Web Portal at www.mmis.georgia.gov which shall constitute formal notices to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

3 Member Eligibility

3.1 Overview

The DCH establishes eligibility criteria for Medicaid/PeachCare for Kids® benefits based upon federal regulations. For detailed member eligibility information, please see the applicable DCH Provider Policy and Procedures Manual.

3.2 How to Verify Member Eligibility

It is the responsibility of the provider to verify Medicaid/PeachCare for Kids® eligibility on each date of service. Members are issued Medicaid/PeachCare for Kids® identification cards (see below) which should be presented on each date of service. Providers must verify eligibility by accessing the Gainwell Technologies Web Portal at www.mmis.georgia.gov, or using the Interactive Voice Response System (IVRS) at 1-800-766-4456. Both the Web Portal and IVRS are available 24 hours per day, seven days a week. Member eligibility verification can be processed through the Web Portal either individually or in batch by submitting a Health Insurance Portability and Accountability Act (HIPAA) compliant transaction. Providers may also submit a written request for eligibility verification to:

Gainwell Technologies

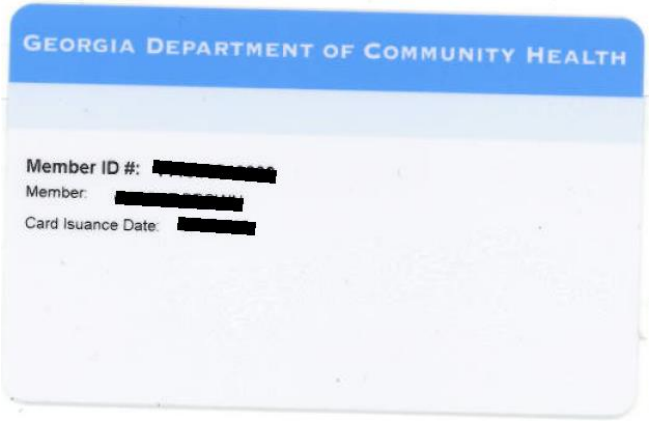
P.O. Box 105200

Tucker, Georgia 30085-5200

3.3 Valid types of Member Identification

3.3.1 Medicaid/PeachCare for Kids® Identification Card

This card replaces former member ID cards for both FFS Medicaid and PeachCare for Kids® Plans.



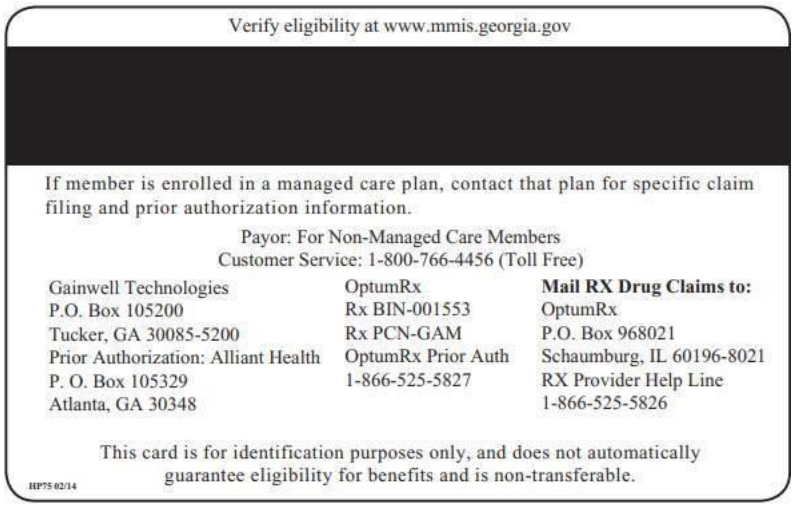
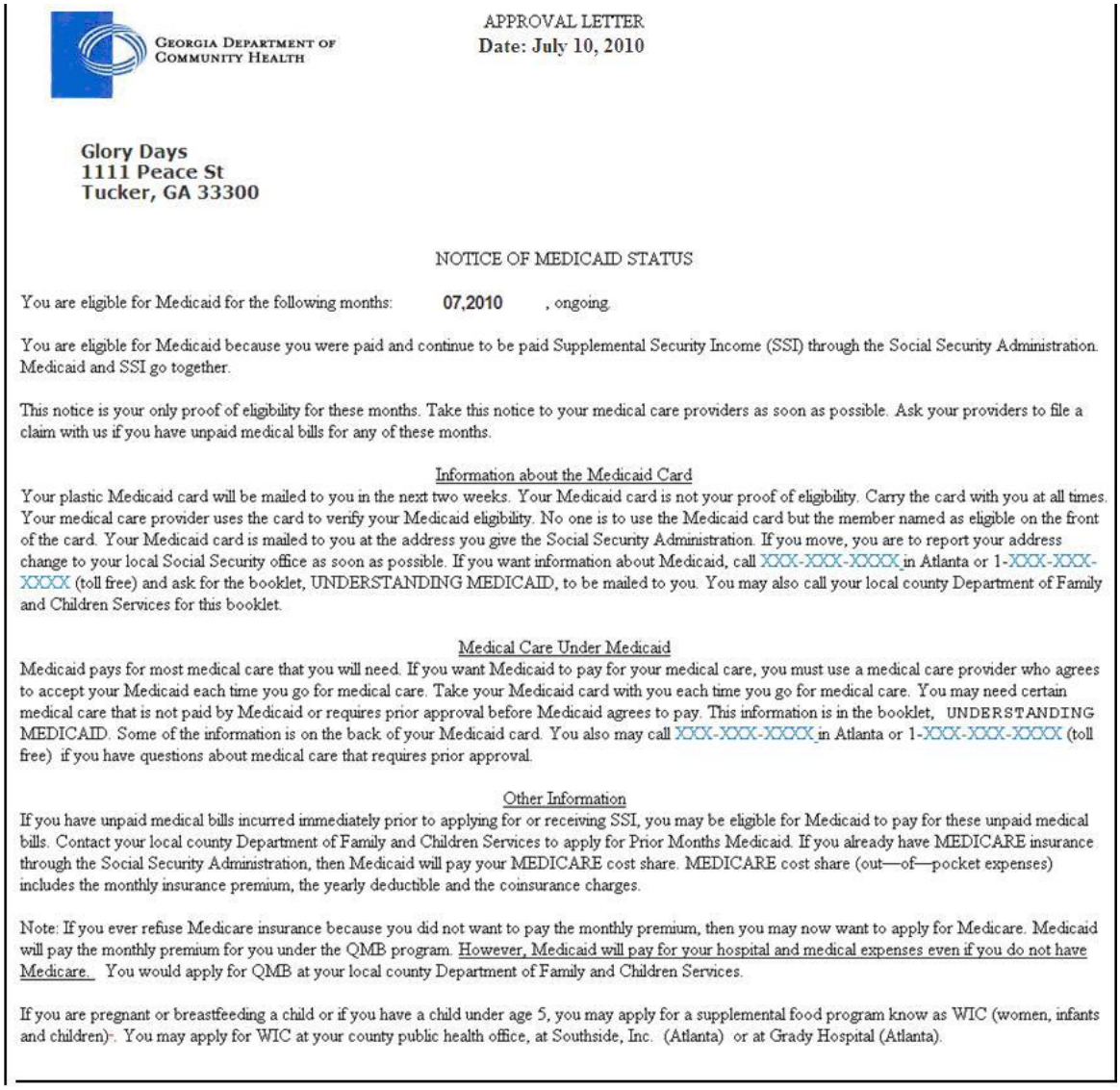


Figure 1: Front and Back of the Medicaid/PeachCare for Kids® Identification Card

3.3.2 Supplemental Security Income Notification Letter

This letter is issued by the DCH to the member. If the date of service falls within the specified months, the letter serves to verify the member's eligibility. Use the name and Medicaid number designated in the letter when completing the claim. If a copy of this letter is required with a claim that is submitted electronically or using the Web Portal, send it with the Electronic Attachment Form and fax it to Gainwell Technologies at 1-866-483-1044 (see form in Appendix C.11).



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

APPROVAL LETTER
Date: July 10, 2010

Glory Days
1111 Peace St
Tucker, GA 33300

NOTICE OF MEDICAID STATUS

You are eligible for Medicaid for the following months: 07,2010 , ongoing.

You are eligible for Medicaid because you were paid and continue to be paid Supplemental Security Income (SSI) through the Social Security Administration. Medicaid and SSI go together.

This notice is your only proof of eligibility for these months. Take this notice to your medical care providers as soon as possible. Ask your providers to file a claim with us if you have unpaid medical bills for any of these months.

Information about the Medicaid Card

Your plastic Medicaid card will be mailed to you in the next two weeks. Your Medicaid card is not your proof of eligibility. Carry the card with you at all times. Your medical care provider uses the card to verify your Medicaid eligibility. No one is to use the Medicaid card but the member named as eligible on the front of the card. Your Medicaid card is mailed to you at the address you give the Social Security Administration. If you move, you are to report your address change to your local Social Security office as soon as possible. If you want information about Medicaid, call XXX-XXX-XXXX in Atlanta or 1-XXX-XXX-XXXX (toll free) and ask for the booklet, UNDERSTANDING MEDICAID, to be mailed to you. You may also call your local county Department of Family and Children Services for this booklet.

Medical Care Under Medicaid

Medicaid pays for most medical care that you will need. If you want Medicaid to pay for your medical care, you must use a medical care provider who agrees to accept your Medicaid each time you go for medical care. Take your Medicaid card with you each time you go for medical care. You may need certain medical care that is not paid by Medicaid or requires prior approval before Medicaid agrees to pay. This information is in the booklet, UNDERSTANDING MEDICAID. Some of the information is on the back of your Medicaid card. You also may call XXX-XXX-XXXX in Atlanta or 1-XXX-XXX-XXXX (toll free) if you have questions about medical care that requires prior approval.

Other Information

If you have unpaid medical bills incurred immediately prior to applying for or receiving SSI, you may be eligible for Medicaid to pay for these unpaid medical bills. Contact your local county Department of Family and Children Services to apply for Prior Months Medicaid. If you already have MEDICARE insurance through the Social Security Administration, then Medicaid will pay your MEDICARE cost share. MEDICARE cost share (out—of—pocket expenses) includes the monthly insurance premium, the yearly deductible and the coinsurance charges.

Note: If you ever refuse Medicare insurance because you did not want to pay the monthly premium, then you may now want to apply for Medicare. Medicaid will pay the monthly premium for you under the QMB program. However, Medicaid will pay for your hospital and medical expenses even if you do not have Medicare. You would apply for QMB at your local county Department of Family and Children Services.

If you are pregnant or breastfeeding a child or if you have a child under age 5, you may apply for a supplemental food program know as WIC (women, infants and children). You may apply for WIC at your county public health office, at Southside, Inc. (Atlanta) or at Grady Hospital (Atlanta).

Figure 2: Supplemental Security Income Notification Letter

3.3.3 Certification of Supplemental Security Income Eligibility Letter

The Social Security Administration issues this letter. If the Date of Service is included within the specified month, this letter serves as verification of the member's eligibility. Use the name and Medicaid number designated on the letter when completing the claim, and keep a copy of the letter for your records. The Medicaid ID number can be used to verify eligibility. This information will also appear on your Remittance Advice (RA). If a copy of this letter is required with a claim that is submitted electronically or using the Web Portal, send it with the Electronic Attachment Form and fax it to Gainwell Technologies at 1-866-483-1044 (see form in Appendix C.11).

3.3.4 Temporary Medicaid Certification Notification (Form 962)

This letter is generated by the local Department of Family and Children Services (DFCS) office in response to a member's request for eligibility verification. Use the name and Medicaid number as it appears on this letter when completing the claim form, and keep a copy of the letter for your records. The Medicaid ID number can be used to verify eligibility. If a copy of this letter is required with a claim that is submitted electronically or using the Web Portal, send it with the Electronic Attachment Form and fax it to Gainwell Technologies at 1-866-483-1044 (see form in Appendix C.11).

Gainwell Technologies
PO BOx 105200
Tucker GA 30085

Mail to:

Georgia Department of Human Resources

Certification of Medicaid Eligibility

_____ County DFCS

County Code: _____

GHP Action Needed: ☐ Add ☐ Correction

Case Name: _____

Address: _____

_____

_____

AU #: _____

Eligibility Status: ☐ Approved Ongoing
☐ Denied Ongoing

BASIS OF ISSUANCE	REASON FOR ISSUANCE
☐ Final Disposition: _____(date)	☐ Newly Eligible/DFCS
☐ RAPS Approval: _____(date)	☐ Newly Eligible/SSI
☐ SSI Cert Letter: _____(date)	☐ Medicaid Card Lost/Stolen
☐ NH/Waiver Authorization: _____ (date)	☐ Non Receipt of Medicaid Card
☐ Web Portal/IVR: _____(elig date)	☐ Verification of Historical Months
☐ Manually Updated on MHN: _____ CIC Contact: _____	

This is to certify that the following individual(s) is eligible for medical assistance in the month(s) listed below:

Name (Last, First, MI)	DOB	Race	Gender	MHN Aid Code	SSN	Client ID or MHN ID	Eff Date	End Date

MN Cases: First Day Liability: _____ Form(s) 400 Required: Y N Pharmacy is Break-Even Bill: Y N

Comments: _____

DFCS Certification of Medicaid Eligibility:

_____ _____ _____

(Print or Type Caseworker Name) (Caseworker Signature) (Telephone Number)

To be signed ONLY after months are active on SUCCESS, added to/active on MHN or SSI Cert Letter is in hand.

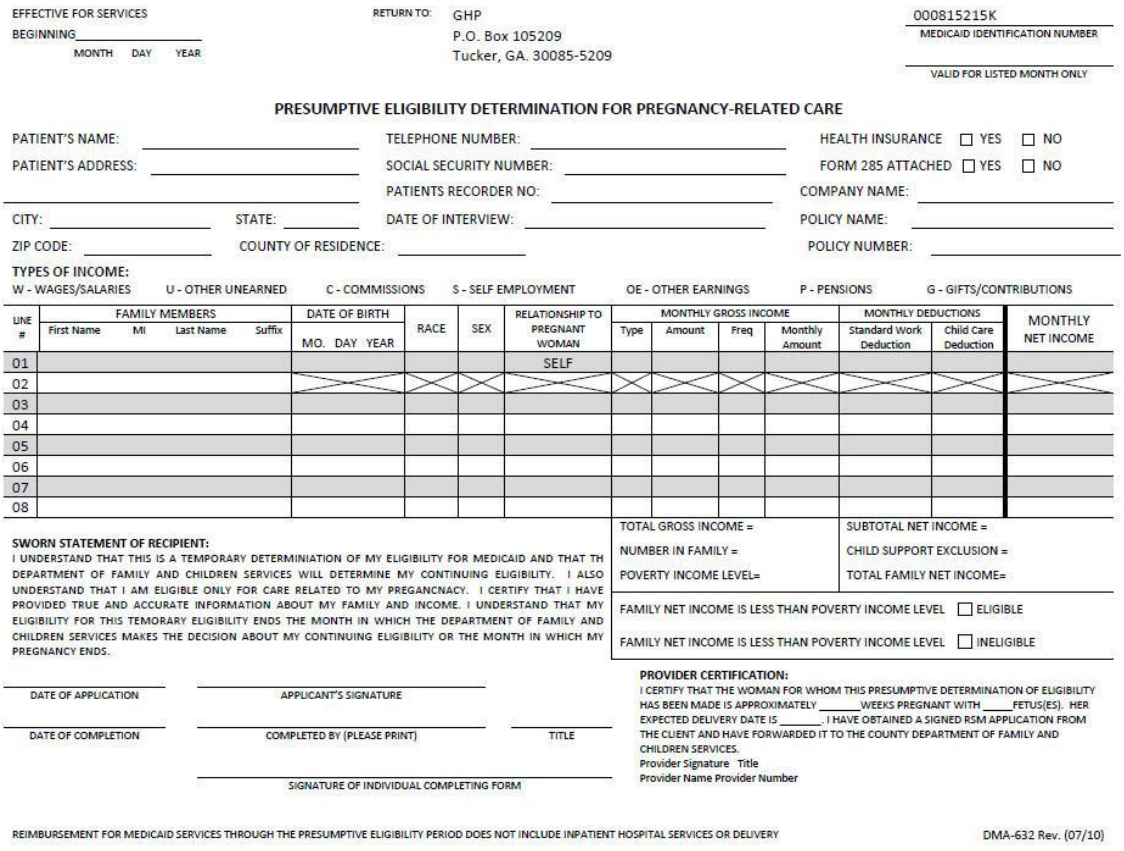
Form 962 (Rev. 07/03) White Copy: Member/Provider Yellow Copy: GHP Pink Copy: Case Record

Figure 3: Temporary Medicaid Certification Notification (Form 962)

3.3.5 Presumptive Eligibility for Pregnant Women Worksheet (DMA-632)

The qualified provider issues the DMA-632 to the presumptively eligible member. The DMA-632 serves as the member's temporary identification card and may be used as confirmation of presumptive eligibility for the Medicaid program as of the indicated date. The qualified provider should print the computer generated form, produced using the Web Portal (see figure 7) and give it to the member. The member receives the green copy of the worksheet if hand generated. Either the computer generated or green copy serves as the first month's Medicaid certification. A member can use the form until the permanent member identification card arrives.

Note: Presumptive eligibility covers all Medicaid services except inpatient hospital services and delivery procedures.



EFFECTIVE FOR SERVICES BEGINNING_____ MONTH DAY YEAR

RETURN TO: GHP P.O. Box 105209 Tucker, GA. 30085-5209

000815215K MEDICAID IDENTIFICATION NUMBER

VALID FOR LISTED MONTH ONLY

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANCY-RELATED CARE

PATIENT'S NAME: _____ TELEPHONE NUMBER: _____ HEALTH INSURANCE ☐ YES ☐ NO

PATIENT'S ADDRESS: _____ SOCIAL SECURITY NUMBER: _____ FORM 285 ATTACHED ☐ YES ☐ NO

_____ PATIENTS RECORDER NO: _____ COMPANY NAME: _____

CITY: _____ STATE: _____ DATE OF INTERVIEW: _____ POLICY NAME: _____

ZIP CODE: _____ COUNTY OF RESIDENCE: _____ POLICY NUMBER: _____

TYPES OF INCOME:
W - WAGES/SALARIES U - OTHER UNEARNED C - COMMISSIONS S - SELF EMPLOYMENT OE - OTHER EARNINGS P - PENSIONS G - GIFTS/CONTRIBUTIONS

LINE #	FAMILY MEMBERS First Name	MI	Last Name	Suffix	DATE OF BIRTH MO. DAY YEAR	RACE	SEX	RELATIONSHIP TO PREGNANT WOMAN	MONTHLY GROSS INCOME Type	Amount	Freq	Monthly Amount	MONTHLY DEDUCTIONS Standard Work Deduction	Child Care Deduction	MONTHLY NET INCOME
01								SELF							
02															
03															
04															
05															
06															
07															
08															

SWORN STATEMENT OF RECIPIENT:
I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINIATION OF MY ELIGIBILITY FOR MEDICAID AND THAT TH DEPARTMENT OF FAMILY AND CHILDREN SERVICES WILL DETERMINE MY CONTINUING ELIGIBILITY. I ALSO UNDERSTAND THAT I AM ELIGIBLE ONLY FOR CARE RELATED TO MY PREGANCNACY. I CERTIFY THAT I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME. I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMORARY ELIGIBILITY ENDS THE MONTH IN WHICH THE DEPARTMENT OF FAMILY AND CHILDREN SERVICES MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY OR THE MONTH IN WHICH MY PREGNANCY ENDS.

TOTAL GROSS INCOME = SUBTOTAL NET INCOME =

NUMBER IN FAMILY = CHILD SUPPORT EXCLUSION =

POVERTY INCOME LEVEL= TOTAL FAMILY NET INCOME=

FAMILY NET INCOME IS LESS THAN POVERTY INCOME LEVEL ☐ ELIGIBLE

FAMILY NET INCOME IS LESS THAN POVERTY INCOME LEVEL ☐ INELIGIBLE

_____ DATE OF APPLICATION _____ APPLICANT'S SIGNATURE

_____ DATE OF COMPLETION _____ COMPLETED BY (PLEASE PRINT) _____ TITLE

_____ SIGNATURE OF INDIVIDUAL COMPLETING FORM

PROVIDER CERTIFICATION:
I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY _____WEEKS PREGNANT WITH ____FETUS(ES). HER EXPECTED DELIVERY DATE IS _____. I HAVE OBTAINED A SIGNED RSM APPLICATION FROM THE CLIENT AND HAVE FORWARDED IT TO THE COUNTY DEPARTMENT OF FAMILY AND CHILDREN SERVICES.
Provider Signature Title
Provider Name Provider Number

REIMBURSEMENT FOR MEDICAID SERVICES THROUGH THE PRESUMPTIVE ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL SERVICES OR DELIVERY

DMA-632 Rev. (07/10)

Figure 4: Presumptive Eligibility for Pregnant Women Worksheet (DMA-632)

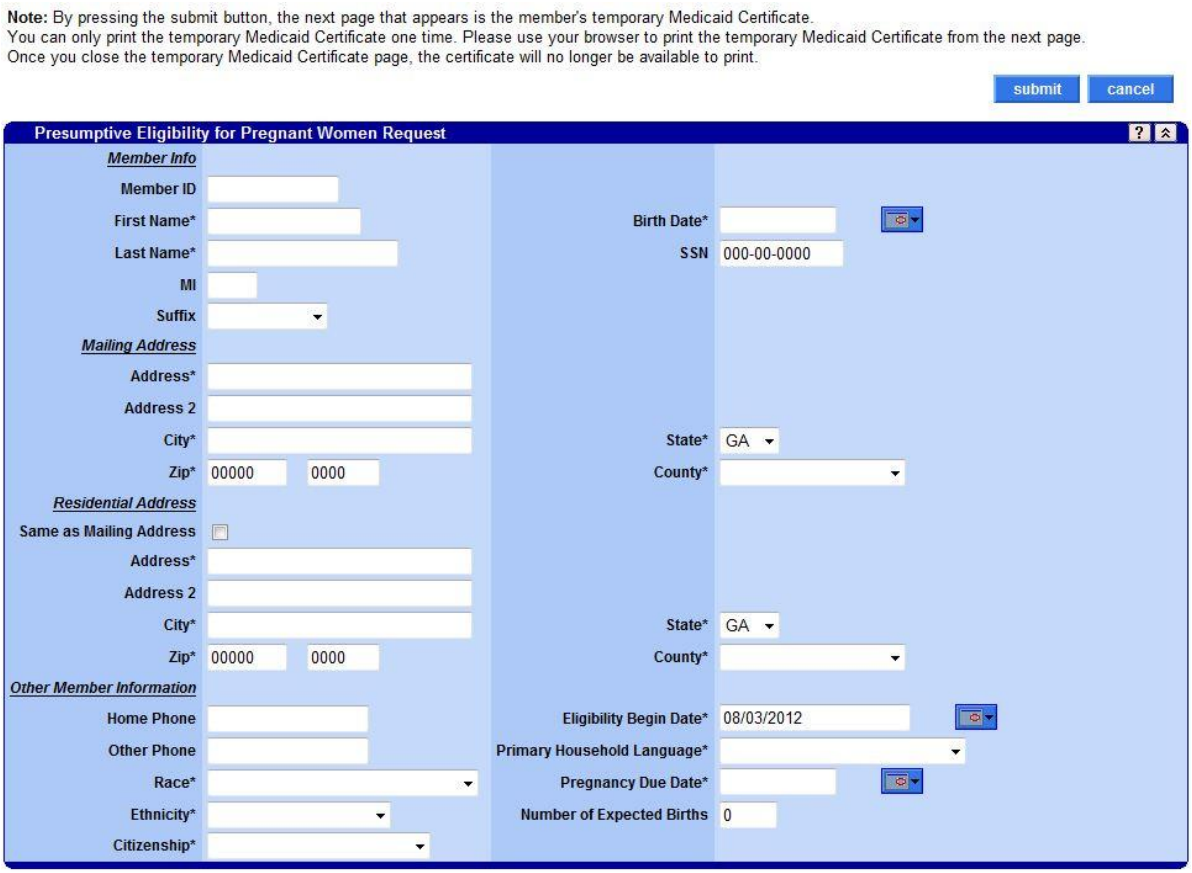
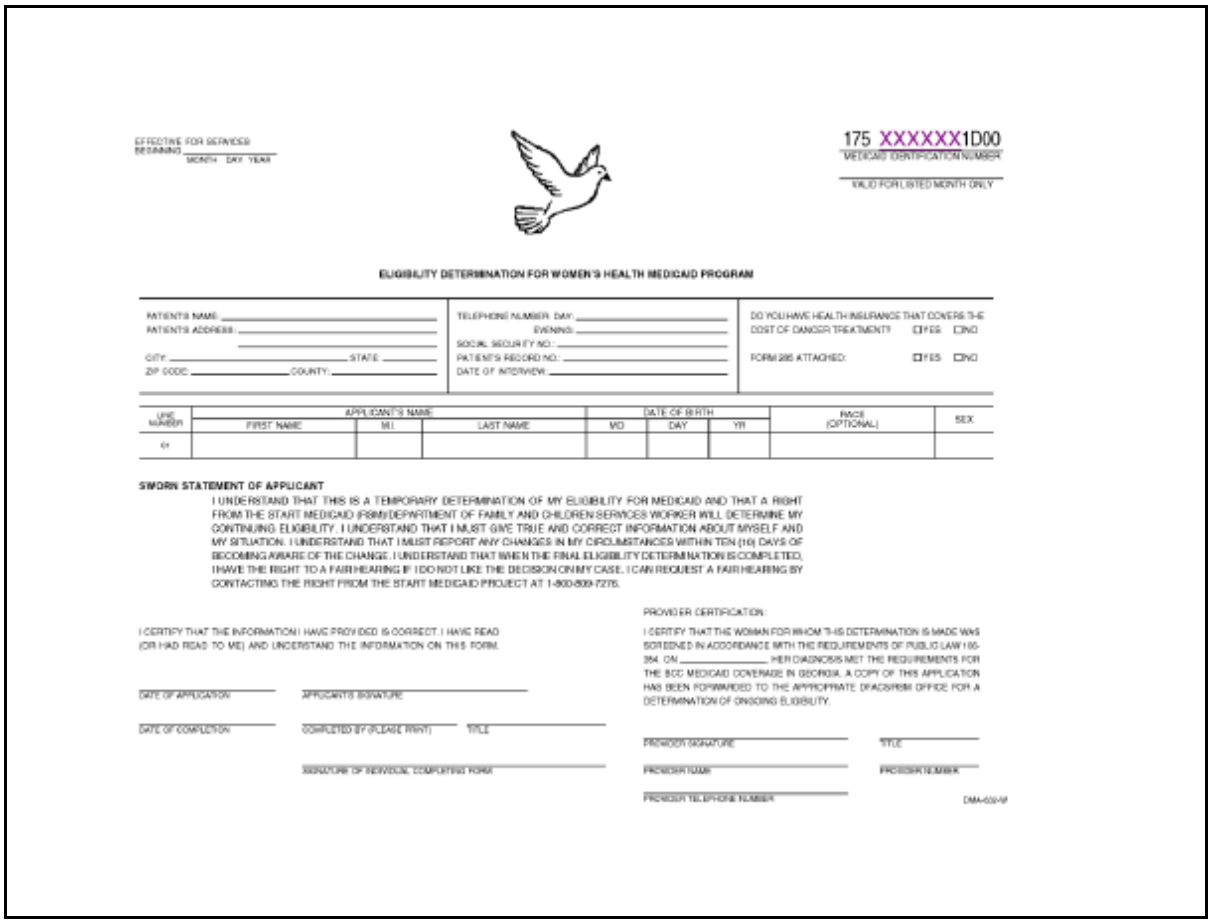


Figure 5: Presumptive Eligibility for Pregnant Women (Computer Generated)

Note: Presumptive eligibility covers all Medicaid services *except* inpatient hospital services and delivery procedures.

3.3.6 Presumptive Eligibility for Women's Health Medicaid Worksheet (DMA-632W)

The Women's Health Medicaid program is for women who have been through special screenings and have a diagnosis of breast or cervical cancer. The qualified provider issues the DMA-632W worksheet, which is either hand-written or computer generated, to the presumptively eligible member. This worksheet serves as the first month's Medicaid certification (See figure 7 for hand-written and figure 8 for an example of the computer generated form.)



EFFECTIVE FOR SERVICES BEGINNING
MONTH DAY YEAR

175 XXXXXX1D00
MEDICAID CERTIFICATION NUMBER

VALID FOR LISTED MONTH ONLY

ELIGIBILITY DETERMINATION FOR WOMEN'S HEALTH MEDICAID PROGRAM

PATIENT'S NAME:
PATIENT'S ADDRESS:
CITY: STATE:
ZIP CODE: COUNTY:

TELEPHONE NUMBER: DAY:
EVENING:
SOCIAL SECURITY NO.:
PATIENT'S RECORD NO.:
DATE OF INTERVIEW:

DO YOU HAVE HEALTH INSURANCE THAT COVERS THE COST OF CANCER TREATMENT? ☐YES ☐NO

FORM 295 ATTACHED: ☐YES ☐NO

LINE NUMBER	APPLICANT'S NAME			DATE OF BIRTH			RACE (OPTIONAL)	SEX
	FIRST NAME	MI	LAST NAME	MO	DAY	YR		
01								

SWORN STATEMENT OF APPLICANT

I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILITY FOR MEDICAID AND THAT A RIGHT FROM THE START MEDICAID (RSM)/DEPARTMENT OF FAMILY AND CHILDREN SERVICES WORKER WILL DETERMINE MY CONTINUING ELIGIBILITY. I UNDERSTAND THAT I MUST GIVE TRUE AND CORRECT INFORMATION ABOUT MYSELF AND MY SITUATION. I UNDERSTAND THAT I MUST REPORT ANY CHANGES IN MY CIRCUMSTANCES WITHIN TEN (10) DAYS OF BECOMING AWARE OF THE CHANGE. I UNDERSTAND THAT WHEN THE FINAL ELIGIBILITY DETERMINATION IS COMPLETED, I HAVE THE RIGHT TO A FAIR HEARING IF I DO NOT LIKE THE DECISION ON MY CASE. I CAN REQUEST A FAIR HEARING BY CONTACTING THE RIGHT FROM THE START MEDICAID PROJECT AT 1-800-609-7276.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT. I HAVE READ (OR HAD READ TO ME) AND UNDERSTAND THE INFORMATION ON THIS FORM.

DATE OF APPLICATION
APPLICANT'S SIGNATURE

DATE OF COMPLETION
COMPLETED BY (PLEASE PRINT)
TITLE

SIGNATURE OF INDIVIDUAL COMPLETING FORM

PROVIDER CERTIFICATION:

I CERTIFY THAT THE WOMAN FOR WHOM THIS DETERMINATION IS MADE WAS SCREENED IN ACCORDANCE WITH THE REQUIREMENTS OF PUBLIC LAW 160-354. ON _____ HER DIAGNOSIS MET THE REQUIREMENTS FOR THE BCC MEDICAID COVERAGE IN GEORGIA. A COPY OF THIS APPLICATION HAS BEEN FORWARDED TO THE APPROPRIATE DFACS/RSM OFFICE FOR A DETERMINATION OF ONGOING ELIGIBILITY.

PROVIDER SIGNATURE
TITLE
PROVIDER NAME
PROVIDER NUMBER
PROVIDER TELEPHONE NUMBER

DMA-632-W

Figure 6: Presumptive Eligibility for Women's Health Medicaid Worksheet (DMA-632W)

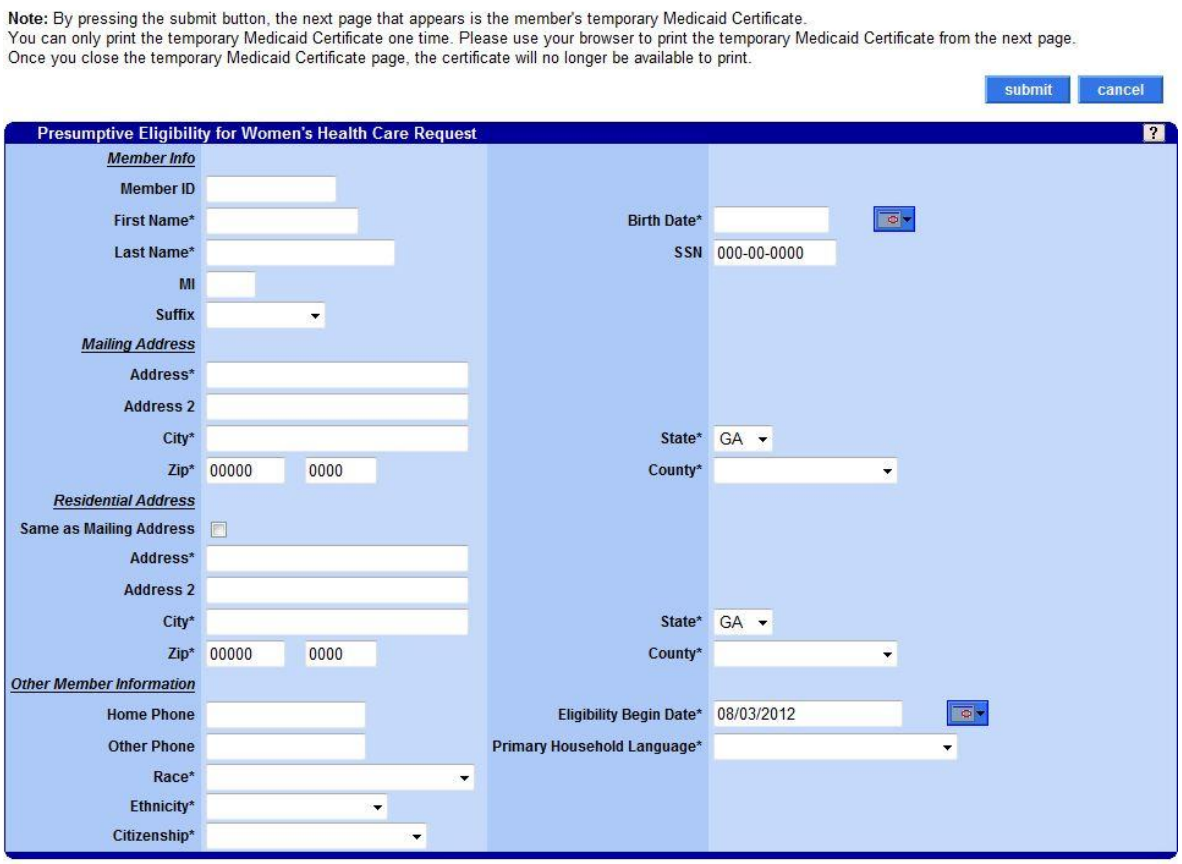
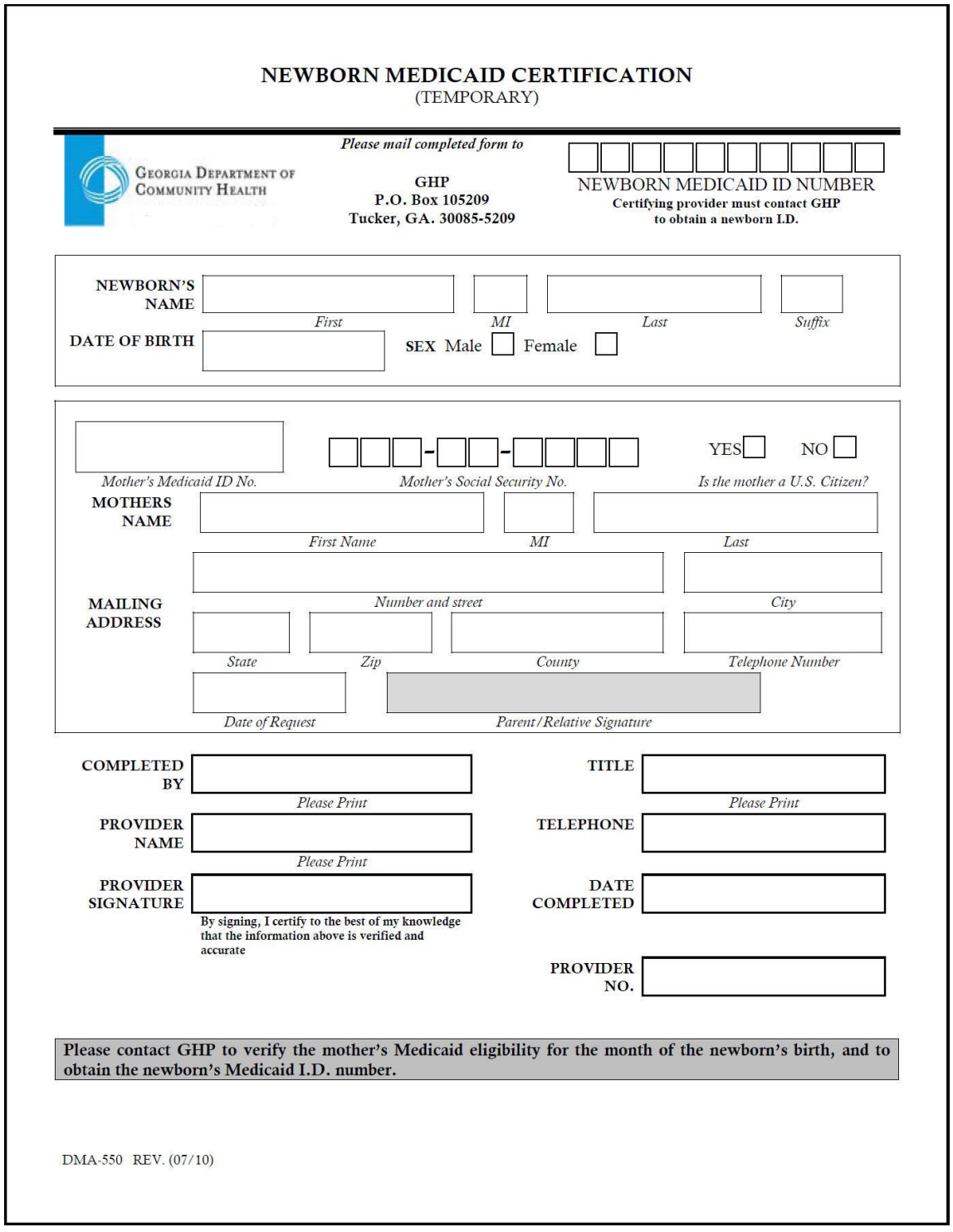


Figure 7: Presumptive Eligibility for Women's Health Medicaid (Computer Generated)

3.3.7 Newborn Eligibility (DMA-550)

The qualified provider issues the DMA-550 worksheet to a newborn's mother. This worksheet serves as the first month's Medicaid certification. There is also a computer generated DMA-550 worksheet that is produced using the Web Portal. (See figure 9 for hand-written and figure 10 for an example of the computer generated form.)

Note: The Web Portal newborn eligibility site, limits qualified providers to entering only one newborn. The Web Portal should not be used for submitting newborn eligibility for multiple births. Qualified providers must submit the newborn eligibility form directly to Gainwell Technologies to have the additional newborn information and eligibility added.



NEWBORN MEDICAID CERTIFICATION
(TEMPORARY)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please mail completed form to

GHP
P.O. Box 105209
Tucker, GA. 30085-5209

NEWBORN MEDICAID ID NUMBER
Certifying provider must contact GHP to obtain a newborn I.D.

NEWBORN'S NAME *First* *MI* *Last* *Suffix*

DATE OF BIRTH **SEX** Male ☐ Female ☐

Mother's Medicaid ID No. *Mother's Social Security No.* ☐☐☐-☐☐-☐☐☐☐ YES☐ NO☐ *Is the mother a U.S. Citizen?*

MOTHERS NAME *First Name* *MI* *Last*

MAILING ADDRESS *Number and street* *City* *State* *Zip* *County* *Telephone Number*

Date of Request *Parent/Relative Signature*

COMPLETED BY *Please Print* **TITLE** *Please Print*

PROVIDER NAME *Please Print* **TELEPHONE**

PROVIDER SIGNATURE **By signing, I certify to the best of my knowledge that the information above is verified and accurate**

DATE COMPLETED

PROVIDER NO.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

DMA-550 REV. (07/10)

Figure 8: Newborn Eligibility Worksheet (DMA-550)

Figure 9: Newborn Eligibility (Computer Generated)

4 Completing the CMS-1500 Claim Form

4.1 Overview

Medicaid cannot make payments to a provider who performs services to a Medicaid member unless the provider submits a claim for reimbursement.

Federal regulations prohibit providers from charging members, the Georgia Medicaid Agency, or Gainwell Technologies a fee for completing or filing Medicaid claim forms. The cost of filing a claim is considered part of the usual and customary charges for all members.

This chapter provides basic information for filing claims. The information is specific to providers who can bill on the CMS-1500 form; it is intended to give all providers an understanding of the various methods for claims submission and instructions on completing the claim form. Once you understand the information in this section, you will need to refer to your specific provider type in the Part II Policy and Procedures Manual chapter that details specific billing instructions for your services.

This chapter describes how to complete and submit the CMS-1500 claim form (02/12) for payment from the Georgia Medicaid Program through Gainwell Technologies.

4.2 Providers Responsibility

Georgia Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Georgia Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This manual contains the claims processing requirements for Georgia Medicaid, including the requirements necessary to comply with HIPAA.

4.3 Providers Who Are Required to Bill on the CMS-1500 Claim Form

The following providers, **must bill on a CMS-1500 claim form** to receive Medicaid reimbursement:

- Ambulance and other transportation services
- Community Care Services Program (CCSP)
- Comprehensive Support Waiver (COMP)
- Community mental health services
- Diagnostic Screening and Prevention Services (DSPS)
- Diagnosis and treatment [Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)]
- Durable Medical Equipment (DME) suppliers

- Family planning services
- Federally qualified healthcare centers
- Free standing rural health centers
- Home health
- Independent Care Waiver Program (ICWP)
- Laboratories
- New Options Waiver (NOW)
- Orthotics and Prosthetics and Hearing Services (O&P)
- Physicians and professional services
- At-Risk of Incarceration Case Management
- Child Protective Services Case Management
- Adult Protective Services Case Management
- Adults with AIDS Case Management
- Perinatal Case Management
- Service Options Using Resources in Community Environments (SOURCE)
- Vision
- Therapists (speech, physical, and occupational)

4.4 Dental Services Billed on the CMS-1500 Claim Form

Dental providers must complete a CMS-1500 claim form (02/12) for the procedure codes listed in the Part II Policy and Procedures for Oral and Maxillofacial Surgery Services Manual. Only dentists enrolled in the Medicaid program as oral surgeons may bill these codes. This manual is available at the Gainwell Technologies Web Portal at www.mmis.georgia.gov.

4.5 Time Limit for Submission of a Claim Form

4.5.1 Timely Claim Submission

Medicaid providers must submit claims within six months after the month in which services were rendered. DCH urges providers to submit claims immediately after providing services so that the claim can be corrected if necessary, and then resubmitted before the filing deadline. See chapter 200 in the Part I Policy and Procedures Manual for detailed information on Timely Submission.

4.5.2 Clean Claim

In order for a claim to be paid, it must be a clean claim. A clean claim means a claim that:

- Has been completed properly according to Medicaid billing guidelines on the CMS-1500 claim form (02/12) with red dropout ink.
- Is accompanied by all necessary documentation required by federal law, state law, or state administrative rule for payment; and
- Can be processed and adjudicated without obtaining additional information from the provider or from a third party.

4.5.3 Six-Month Filing Limit

A clean claim for services rendered must be received by Gainwell Technologies within six months after the month the services were rendered.

4.5.4 Out-Of-State Claims

Claims submitted by an out-of-state provider must be received by Gainwell Technologies within 12 months after the month services were rendered.

Out-of-state providers must comply with all other Georgia Medicaid claim filing time limits.

4.5.5 Date Received Determined

The 13-digit ICN contains the region code, date of receipt, and a sequence number. The format is RRYYDDDSSSSSS. The date electronically coded on the provider's electronic transmission by Gainwell Technologies is the recorded date of receipt for an electronically submitted claim.

4.5.6 Medicare/Medicaid Crossover Claims

Claims in this category must be received within 12 months from the month of service at the address used for regular claims submission. A provider must wait at least 45 days from the date of payment by Medicare and not automatically sent by the Medicare Carrier or Intermediary to submit a Medicare crossover claim.

4.5.7 Third Party Payer or Insurance Claims

Claims originally filed timely with a third party carrier, but were denied or paid insufficiently, must be billed to Medicaid within three months from the date of the denial or payment, but never more than 12 months from the month of service. Claims filed timely with a third party carrier, but did not generate a response from the carrier, despite all reasonable actions taken, may be filed with Medicaid using the Coordination of Benefits (COB) Notification Form attachment, (DMA-410), indicating no response was received.

Note: Please refer to the Part I Policy and Procedures Manual and the Medicaid Secondary User Guide for detail COB requirements.

4.6 Basic Guidelines for Completing a Claim Form

4.6.1 Claims Submission

Claims can be submitted to Gainwell Technologies using four methods:

- **EDI (Electronic Data Interchange**) – Files containing HIPAA compliant transactions can be uploaded or downloaded from a secure file transfer server.
- **Online Claims Submission** – Claims are completed using data input screens available to users in a secure area of the provider Web Portal.
- **PES (Provider Electronic Solution)** – Claims can be submitted from a provider's personal computer using software provided by Gainwell Technologies.

4.6.2 Ordering the Claim Form

Gainwell Technologies does not supply the CMS-1500 claim form. Please contact your local print vendor or Internet health care forms vendor.

4.6.3 Completion of the CMS-1500 Claim Form

There are some basic rules to follow before completing the claim form.

- Make sure the CMS-1500 is the right form to use for your provider type (**CMS-1500 claim form (02/12) with red dropout ink**).
- Use one claim form per member.
- Enter only one procedure code per claim line.
- Enter all information in black type or ink. Gainwell Technologies can only process claims with black type or ink.
- Be sure the information on the form is legible.
- Enter information within the allotted spaces.
- Do not use correction fluid on the claim form; correction tape is acceptable.
- Complete the form using the service-specific Part II Policies and Procedures Manual for coverage and limitations as a reference.
- Follow the instructions found in this manual for completing the CMS-1500 claim form for Medicaid reimbursement. Some fields are not self-explanatory or have multiple uses based on the provider type, so if you are uncertain as to how to complete an item on the claim form, please refer to this manual for the most comprehensive and correct instructions. Incorrect entries can result in denied Medicaid claims.

4.6.4 Before Completing the Form

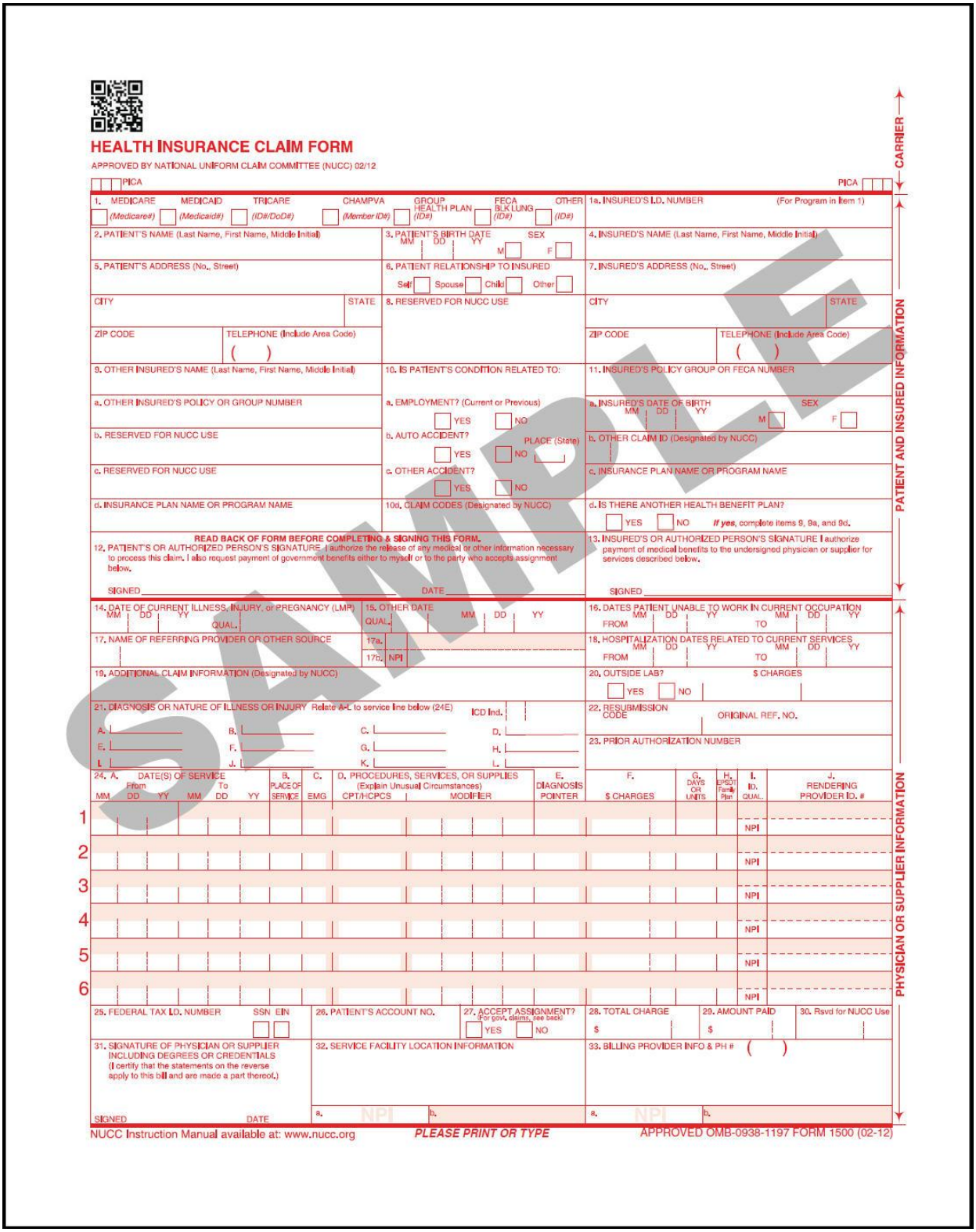
Before filling out the claim form, answer the following questions:

- Was the member eligible for Medicaid on the date of service?
- Has the member's eligibility been verified?
- Was the service or item covered by Medicaid?
- Was prior authorization / precertification obtained, if applicable?
- Has a claim been filed and a response received for all the member's other insurance?
- Was the procedure within the service limitations?
- Does this claim require any medical documentation or attachment?

If all of the above information is not available, review the instructions in this manual. If the response to all of the above, applicable questions is "yes," fill out the claim form following the step-by-step instructions for each item on the form, referring to this manual for clarification when necessary.

4.7 How to Complete the CMS-1500 Claim Form

Following is an example of the Centers for Medicare and Medicaid Services 1500 (CMS-1500) form. The revised CMS-1500 claim form was effective beginning January 1, 2014.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Figure 3: CMS-1500 Claim Form

This section contains an illustration of the CMS-1500 claim form and step-by-step instructions.

CMS has revised its Health Insurance Claim Form (CMS-1500). The revisions accommodate various billing requirements, such as the National Provider Identification (NPI) number and National Drug Code number (NDC), etc. Effective January 1, 2014, providers are required to submit the new CMS-1500 claim form for all related services.

The following table provides a brief description of the fields located on the CMS-1500 claim form and instructions for completing. The alphanumeric data located in the **1500 Form Locator** column identifies the area/location of the field on the CMS-1500 Form. The data located in the **837 Loop ID and 837 Segment/Data Element** column identifies the location where the data is received within the ASC X12 Standards for Electronic Data Interchange Technical Report Type (TR3) Health Care Claim Professional (837P) transaction. Data is entered by the provider in this area on the claim form. The data located in the **Field Name** column identifies and names the field for the given location. The alpha character shown in the **Required Information** denotes the following:

- R - Required
- C - Conditionally required, if applicable

The information located under the **Guidelines** area explains what you should enter in each field on the CMS-1500 claim form or the 837P transaction. Please refer to your specific provider type in the Part II Policy and Procedures Manual for detailed billing instructions.

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
Claim Level Information					
1	N/A	N/A	Health insurance coverage	R	CMS-1500: Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicaid claim is being filed, enter an X in the Medicaid box.

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
1a	2010BA	NM109	Insured's ID number	R / R	
FL 1a Guidelines for CMS-1500: Enter the member's number from the Medicaid identification card and/or eligibility verification response exactly as it appears. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Member Eligibility**. 837P Guidelines: NM108 = MI					
2	2010BA	NM1	Patient's name	R / R	
FL 2 Guidelines for CMS-1500: Enter the member name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the member name on the claim form must match the name on file for the member number you entered in field 1a**. If a member has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a member first name contains an apostrophe, enter the first name including the apostrophe. **Examples**: For member A. B. Doe, enter "Doe A B" with no punctuation. For member D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces. 837P Guidelines: See mapping below.					
	2010BA	NM103	Patient Last Name	R	837P: NM101 = IL NM102 = 1
	2010BA	NM104	Patient First Name	R	
	2010BA	NM105	Patient Middle Initial	C	
3	2010BA	DMG02	Patient Birth Date	R	CMS-1500: Enter the month, day, and year **(MM/DD/CCYY)** the member was born. 837P: DMG01 = D8

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
					DMG02 Format = CCYYMMDD
		DMG03	Patient Sex	R	CMS-1500: Indicate the member's sex by checking the appropriate box. 837P: Valid Values F = Female M = Male U = Unknown
4	2330A	NM1	Insured's Name	R	
FL 4 Guidelines for CMS-1500: **If Medicaid is primary, leave blank. No entry required unless the member is covered by other insurance**. If there is insurance primary to Medicaid, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. 837P Guidelines: See mapping below.					
	2010BA	NM103	Insured's Last Name	R	837P: NM101 = IL NM102 = 1
	2010BA	NM104	Insured's First Name	R	
	2010BA	NM105	Insured's Middle Initial	C	
5	2010BA	N3, N4	Patient's Address	C / R	CMS-1500: Enter the patient's complete address as described (city,

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
					state, and ZIP code).
	2010BA	N301	Patient Address 1	R	
	2010BA	N302	Patient Address 2	C	
	2010BA	N401	Patient City	R	
	2010BA	N402	Patient State	R	
	2010BA	N403	Patient Zip Code	R	837P: If Patient Address Zip Code + 4 digit postal code (exclude punctuation and blanks).
6	2320	SBR02	Patient's Relationship to Insured	C	
FL 6 Guidelines for CMS-1500: Check the appropriate box for patient's relationship to insured when item 4 is completed. 837P Guidelines: 2320-SBR02 Valid Values: 01=Spouse, 18=Self, 19=Child, 20=Employee, 21=Unknown, 39=Organ Donor, 40=Cadaver Donor, 53=Life Partner, G8=Other Relationship					
7	2330A	N3, N4	Insured's Address	C	CMS-1500: Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when form location items 4, 6, and 11 are completed.

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
	2330A	N301	Insured's Address 1	C	
	2330A	N302	Insured's Address 2	C	
	2330A	N401	Insured's City	C	
	2330A	N402	Insured's State	C	
	2330A	N403	Insured's Zip Code	C	837P: If Insured's Address Zip Code + 4 digit postal code (exclude punctuation and blanks).
8	N/A	N/A	Reserved for NUCC Use	N/A	CMS-1500: This field was previously used to report "Patient Status." "Patient Status" does not exist in 5010A1, so this field has been eliminated.
9	2320, 2330A	SBR, NM1	Other insured's name	C	
FL 9 Guidelines for CMS1500: If the member has other health insurance coverage, enter all pertinent information. **Providers must submit the claim to other insurers prior to submitting the claim to Medicaid**. **Note**: Form locator items 9 – 9d should be completed for any coverage other than Medicare 837P Guidelines: See mapping below.					
	2330A	NM103	Insured's Last Name	R	837P: NM101 = IL NM102 = 1
	2330A	NM104	Insured's First Name	R	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
	2330A	NM105	Insured's Middle Initial	C	
9a	2320	SBR03	Other insured's policy or group number	C / C	
FL 9a Guidelines for CMS-1500: Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number. The "Other Insured's Policy or Group Number" identifies the policy or group number for coverage of the insured as indicated in Item Number 9. This field allows for the entry of 28 characters. 837P Guidelines: Other Insured's Policy or Group Number. Only SBR03 or SBR04 are allowed, however not both.					
9b	N/A	N/A	Reserved for NCCU Use	N/A	
FL 9b Guidelines for CMS-1500: This field was previously used to report "Other Insured's Date of Birth, Sex." "Other Insured's Date of Birth, Sex" does not exist in 5010A1, so this field has been eliminated.					
9c	N/A	N/A	Reserved for NCCU Use	N/A	
FL 9c Guidelines for CMS-1500: This field was previously used to report "Employer's Name or School Name." "Employer's Name or School Name" does not exist in 5010A1, so this field has been eliminated.					
9d	2320	SBR04	Insurance plan name or program name	C	
FL 9d Guidelines for CMS-1500: Enter the primary insurance plan name. 837P Guidelines: Other Insured's Plan Name. Only SBR03 or SBR04 are allowed, however not both.					
10a	2300	CLM11	Is patient's condition related to	R / C	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
			employment? (Current or previous)		
	2300	CLM11-1	Related Causes Code	C	
	2300	CLM11-2	Related Causes Code	C	
FL 10a Guidelines for CMS-1500: Indicate by checking the appropriate box. If applicable, enter all available information in field 11, "Other Health Insurance Coverage." Enter "X" if treatment related to employment. 837P Guidelines: Valid Values • AA=Auto Accident • EM=Employment • OA=Other Accident					
10b	2300	CLM11-4	Is patient's condition related to auto accident?	C	
FL 10b Guidelines for CMS-1500: Enter "X" if treatment is related to auto accident. 837P Guidelines: State in which auto-accident occurred. Required if CLM11-1 or CLM11-2 = 'AA'.					
10c	2300	CLM11-1, CLM11-2	Is patient's condition related to other accident?	R / C	CMS-1500: Enter "X" if treatment is related to other accident. 837P: See FL 10a
10d	2300	HI01 – HI12	Claim Codes (Designated by NUCC)	C	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
FL 10d Guidelines for CMS-1500: When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the 1500 Claim Form are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code. **FOR WORKERS COMPENSATION CLAIMS:** Condition Codes are required when submitting a bill that is a duplicate or an appeal. (Original Reference Number must be entered in Box 22 for these conditions). Note: Do not use Condition Codes when submitting a revised or corrected bill. The "Claim Codes" identify additional information about the patient's condition or the claim. This field allows for the entry of 19 characters. 837P Guidelines: 2300-HI Segment. Up to 12 Condition Codes are allowed within the HI segment, where HIxx-1 to HIxx-12 = BG					
11	2320	SBR03	Insured's policy group or FECA number	C / C	
FL 11 Guidelines for CMS-1500: Enter insured's policy and/or group number. When billing Medicaid/PeachCare for Kids®, data is not required in this field. 837P Guidelines: Other Insured's Policy or Group Number. Only SBR03 or SBR04 are allowed, however not both.					
11a	N/A	N/A	Insured's date of birth and sex	C	
FL 11a Guidelines for CMS-1500: Enter date of birth and gender, if applicable. Enter date using MM/DD/CCYY format. When billing Medicaid/PeachCare for Kids®, data is not required in this field.					
11b	2010BA	REF	Other Claim ID (Designated by NUCC)	C / C	
FL 11b Guidelines for CMS-1500: Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC. The following qualifier and accompanying identifier has been designated for use: • Y4 Property Casualty Claim Number					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line. **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer. The "Other Claim ID" is another identifier applicable to the claim. 837P Guidelines: • Property & Casualty: 2010BA-REF01=Y4, REF02=Property & Casualty Claim Number.					
11c	2320	SBR04	Insurance plan or benefit plan being billed	C / C	
FL 11c Guidelines for CMS-1500: Enter insurance plan or program name, **if applicable**. When billing Medicaid/PeachCare for Kids®, data is not required in this field. 837P Guidelines: Other Insured's Plan Name. Only SBR03 or SBR04 are allowed, however not both.					
11d	N/A	N/A	Other health benefit plan	C	
FL 11d Guidelines for CMS-1500: Indicate whether another coverage or insurance plan exists. Do not mark "yes" when the other coverage is Medicare. If "YES", the provider should complete form locator items 9 – 9d on the CMS-1500 form for the non-Medicare coverage.					
12	N/A	N/A	Patient's or Authorized Person's Signature	R	CMS-1500: Enter the signature and date using the MM/DD/YY format.
13	N/A	N/A	Insured's or Authorized Person's Signature	C	CMS-1500: Enter signature, only if third party payer.
14	2300	DTP	Date of current illness, injury and/or pregnancy	R / C	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
FL 14 Guidelines for CMS-1500: Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. • 431 Onset of Current Symptoms or Illness • 484 Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line. The "Date of Current Illness, Injury, or Pregnancy" identifies the first date of onset of illness, the actual date of injury, or the LMP for pregnancy. This field allows for the entry of the following: two characters under MM, two characters under DD, four characters under YY, and three characters to the right of the vertical, dotted line. 837P Guidelines: • Illness or Injury Date: 2300-DTP01=431, DTP02=D8, DTP03=DATE (CCYYMMDD). • Last Menstrual Period Date: 2300-DTP01=484, DTP02=D8, DTP03=DATE (CCYYMMDD).					
15	2300	DTP	Other Date	C	
FL 14 Guidelines for CMS-1500: Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported. • 454 Initial Treatment • 304 Latest Visit or Consultation • 453 Acute Manifestation of a Chronic Condition • 439 Accident • 455 Last X-ray • 471 Prescription • 090 Report Start (Assumed Care Date) • 091 Report End (Relinquished Care Date) • 444 First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the patient's condition or treatment. This field allows for the entry of the following: three characters between the vertical, dotted lines, two characters under MM, two characters under DD, and four characters under YY. 837P Guidelines: • Initial Treatment Date: 2300-DTP01=454, DTP02=D8, DTP03=Date (CCYYMMDD).					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
• Last Seen Date: 2300-DTP01=304, DTP02=D8, DTP03= Date (CCYYMMDD). • Acute Manifestation Date: 2300-DTP01=453, DTP02=D8, DTP03= Date (CCYYMMDD). • Accident Date: 2300-DTP01=439, DTP02=D8, DTP03= Date (CCYYMMDD). • Last X-Ray Date: 2300-DTP01=455, DTP02=D8, DTP03= Date (CCYYMMDD). • Hearing and Vision Prescription Date: 2300-DTP01=471, DTP02=D8, DTP03= Date (CCYYMMDD). • Assumed and Relinquished Care Date: 2300-DTP01=090 (Report Start) or DTP01=091 (Report End), DTP02=D8, DTP03= Date (CCYYMMDD). • Property and Casualty Date of First Contact: 2300-DTP01=444, DTP02=D8, DTP03= Date (CCYYMMDD).					
16	2300	DTP03	Dates Patient Unable to Work	C / C	
FL 16 Guidelines for CMS-1500: Enter date in MM/DD/YY format, **if applicable**. 837P Guidelines: • 2300-DTP01=297, DTP02=D8, DTP03=Date (CCYYMMDD).					
17	2310A 2310D 2420D 2420E 2420F	NM1 REF	Name of referring provider or other source	C / C	
FL 17 Guidelines for CMS-1500: Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported: • DN Referring Provider • DK Ordering Provider • DQ Supervising Provider Enter the qualifier to the left of the vertical, dotted line.					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. The qualifier indicates the role of the provider being reported. This field allows for the entry of two characters to the left of the vertical, dotted line and 24 characters to the right of the dotted line. <u>837P Guidelines:</u> See mapping below.					
	2310A	NM103	Claim Level: Referring Provider Last Name	C	<u>837P:</u> NM101=DK NM102=1 (Must not equal 2420F if present)
	2310A	NM104	Claim Level: Referring Provider First Name	C	<u>837P:</u> Must not equal 2420F if present
	2310D	NM103	Claim Level: Supervising Provider Last Name	C	<u>837P:</u> NM101=DQ NM101=1 (Must not equal 2420D if present)
	2310D	NM104	Claim Level: Supervising Provider First Name	C	<u>837P:</u> Must not equal 2420D if present
	2420D	NM103	Detail Level: Supervising Provider Last Name	C	<u>837P:</u> NM101=DQ NM101=1 (Must not equal 2310D if present)
	2420D	NM104	Detail Level: Supervising Provider First Name	C	<u>837P:</u> Must not equal 2310D if present
	2420E	NM103	Detail Level:	C	<u>837P:</u> NM101=DK NM101=1

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
			Ordering Provider Last Name		
	2420E	NM104	Detail Level: Ordering Provider First Name	C	
	2420F	NM103	Detail Level: Referring Provider Last Name	C	837P: NM101=DN NM101=1 (Must not equal 2310A if present)
	2420F	NM104	Detail Level: Referring Provider First Name	C	837P: Must not equal 2310A if present
17a	2310A 2310D 2420D 2420E 2420F	REF	Other ID#	C / C	
FL 17a Guidelines for CMS-1500: The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: • 0B State License Number • 1G Provider UPIN Number • G2 Provider Commercial Number • LU Location Number (This qualifier is used for Supervising Provider only.) The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code. This field allows for the entry of two characters in the qualifier field and 17 characters in the Other ID# field. 837P Guidelines: See mapping below.					
	2310A	REF02	Claim Level:	C	837P: REF01=0B, 1G or G2

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
			Referring Provider Secondary Identification		(Must not equal 2420F if present)
	2310D	REF02	Claim Level: Supervising Provider Secondary Identification	C	837P: REF01=0B, 1G, G2 or LU (Must not equal 2420D if present)
	2420D	REF02	Detail Level: Supervising Provider Secondary Identification	C	837P: REF01=0B, 1G, G2 or LU (Must not equal 2310D if present)
	2420E	REF02	Detail Level: Ordering Provider Secondary Identification	C	837P: REF01=0B, 1G or G2
	2420F	REF02	Detail Level: Referring Provider Secondary Identification	C	837P: REF01=0B, 1G or G2 (Must not equal 2310A if present)
17b	2310A 2310D 2420D 2420E 2420F	NM109	NPI #	C / C	

FL 17b Guidelines for CMS-1500: Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.
The NPI number refers to the HIPAA National Provider Identifier number.
This field allows for the entry of a 10-digit NPI number

837P Guidelines:

- Referring Provider NPI Claim Level: 2310A-NM108=XX, NM109=NPI

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
• Supervising Provider NPI Claim Level: 2310D-NM108=XX, NM109=NPI (Must not equal 2420D if present) • Supervising Provider NPI Detail Level: 2420D-NM108=XX, NM109=NPI (Must not equal 2310D if present) • Ordering Provider NPI Detail Level: 2420E-NM108=XX, NM109=NPI • Referring Provider NPI Detail Level: 2420F-NM108=XX, NM109=NPI (Must not equal 2310A if present)					
18	2300	DTP	Hospitalization Dates Related to Current Services	R / C	
<u>FL 18 Guidelines for CMS-1500:</u> Enter the inpatient six-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization. The "Hospitalization Dates Related to Current Services" would refer to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim. This field allows for the entry of the following in each of the date fields: two characters under MM, two characters under DD, and four characters under YY. <u>837P Guidelines:</u> • Admission Date: 2300-DTP01=435, DTP02=D8, DTP03=DATE (CCYYMMDD). • Discharge Date: 2300-DTP01=096, DTP02=D8, DTP03=DATE (CCYYMMDD).					
19	N/A	N/A	Additional Claim Information (Designated by NUCC)	C	
<u>FL 19 Guidelines for CMS-1500:</u> Please refer to the most current instructions from the public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field. If identifiers are reported in this field, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and the number. When reporting a second item of data, enter three blank spaces and then the next qualifier and number/code/information.					
20	N/A	N/A	Outside Lab	C	<u>CMS-1500:</u> Check "YES" or "NO".

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
					The charges are not necessary.
21	2300	HI01 – HI12	Diagnosis or nature of illness or injury	C / R	

FL 21 Guidelines for CMS-1500: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

- 9 for ICD-9-CM
- 0 for ICD-10-CM

Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.
Enter the codes to identify the patient's diagnosis and/or condition.
List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. This field allows for the entry of one character indicator and 12 diagnosis codes at a maximum of seven characters in length.

837P Guidelines: Up to twelve (12) Diagnosis Codes can be reported (HI01-1 to HI12-12).
For dates of service prior to 10/1/2015, ICD-9-CM qualifier/diagnosis codes must be used.
For dates of service on or after 10/1/2015, ICD-10-CM qualifier/diagnosis codes must be used.

- 2300-HIxx-1 =BK (ICD-9-CM)
- 2300-HIxx-1 = ABK (ICD-10-CM)

- 2300-HIxx-02 = ICD-9-CM or ICD-10-CM Diagnosis Code

22	2300	REF02	Medicaid resubmission code/original reference number	C / C	

FL 22 Guidelines for CMS-1500: List the original reference number for resubmitted claims.
Please refer to the most current instructions from the public or private payer regarding the use of this field (e.g., code).
When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

- 7 Replacement of prior claim
- 8 Void/cancel of prior claim

This Item Number is not intended for use for original claim submissions.

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
"Resubmission" means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter. This field allows for the entry of one character in the Code area and 18 characters in the Original Ref. No. area. <u>837P Guidelines:</u> • 2300-REF01=F8, REF02=Original ICN If, this REF segment is present, 2300-CLM05-3 must equal '7' or '8': • 7 Replacement of prior claim • 8 Void/cancel of prior claim					
23	2300	REF02	Prior Authorization Number	C / C	
<u>FL 23 Guidelines for CMS-1500:</u> Enter the prior authorization number or precertification number (PA/PC) issued by Georgia Medical Care Foundation (GMCF), if applicable. **Do not use for any other number. Leave blank if this does not apply**. <u>837P Guidelines:</u> 2300-REF01=G1, REF02=Prior Authorization Number.					
Detail Level Information					
24a	2400 2410 2400	NTE LIN REF	**Shaded Area only:** enter the VP qualifier followed by the Serial number for specified DME equipment (see DME Part II Policy and Procedures Manual for list).	R	
			Procedure/services/ supplies **(in the shaded area ONLY)**	R	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
			Shaded Area Only: Mammography Certification	C	

FL 24a '**Shaded Area**' Guidelines for CMS-1500:

- DME: Enter the qualifier VP followed by the complete serial number. There is no space between the qualifier and the serial number, example: VPXXXXXXXXXXXX
- Procedure/services/supplies: Enter the 11-digit NDC number, preceded by the two-digit qualifier N4 (the unique two-digit qualifier used to bill injectable drugs), example N4XXXXXXXXXXX. The NDC number should correspond with the HCPCS/CPT code(s) entered in form locator 24d.
- Mammography**:** Enter the EW qualifier followed by the certificate number. There is no space between the qualifier and the certification number. Example EWXXXXXXXXXX.

837P Guidelines:

- DME: 2400-NTE01=ADD, NTE02=DME Serial Number prefixed with DME and end with a semicolon. For Example: DME1234X321;
- NDC: 2410-LIN02=N4, LIN03=11-digit NDC number.
- Mammography Certification: REF01=EW, REF02=Mammography Certification Number.

24a	2400	DTP03	Date of service (DOS)	R / R	

FL 24a **'Unshaded Area'** Guidelines for CMS-1500: Enter the date of service for each procedure provided in a MM/DD/YY format **in the unshaded area**. If identical services (and charges) are performed on the same day, enter the same date of service in both "from" and "to" spaces, and enter the units performed in form locator 24g.

Note: See exception DOS requirements in section 4.7.1.

837P Guidelines:

- DTP01=472, DTP02=RD8, DTP03 = CCYYMMDD-CCYYMMDD (including hyphen for a length of 17).

24b	2300 2400	CLM05 SV105	Place of service (POS)	R /R	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
FL 24a Guidelines for CMS-1500: Enter a valid POS code for each procedure **in the unshaded area**. **Note:** See Place of Service Codes in section 4.7.2. 837P Guidelines: Place of Service is required within the 2300-CLM05-1. Value received will apply to all detail lines, unless a 'different' value is received at the detail within the 2400-SV105. If, a value is sent within the 2400-SV105 it 'must not' equal value sent within the 2300-CLM05-1. • CLM05-1=Place of Service • CLM05-2=B • CLM05-3=1 (Original), 7 (Replacement of prior claim), or 8 (Void/cancel of prior claim)					
24c	2400	SV109	EMG	C / C	
FL 24c Guidelines for CMS-1500: If the procedure code billed was the result of an emergency, enter "Y" for Yes. Otherwise, enter "N" for No or leave blank. 837P Guidelines: If, applicable value = 'Y'.					
24d	2400	SV101	Procedures, Services, or Supplies CPT/HCPCS and MODIFIER	R / R	
FL 24d Guidelines for CMS-1500: Enter **in the unshaded area,** the appropriate five-digit Health Care Financing Administration Common Procedural Coding System (HCPCS) or Current Procedural Terminology (CPT) code(s) that describe procedure/services/supplies. **If billing an injectable drug, the HCPCS/CPT code should correspond with the NDC number in form locator 24a**. Use modifiers, if appropriate. 837P Guidelines: • Procedure Code: 2400-SV101-2, where SV101='HC'. • Modifier(s): Up to four (4), if applicable: 2400-SV101-3 to SV101-6.					
24e	2400	SV107	Diagnosis code	R / R	
FL 24e Guidelines for CMS-1500: In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Enter letters left justified in the field. 837P Guidelines: The first pointer designates the primary diagnosis for this service line. Remaining diagnosis pointers indicate declining level of importance to service line. Acceptable values are 1 through 12, and correspond to the Composite Data Elements 01 through 12 in the 2300-HI01-2 to HI12-2. • Diagnosis Code Pointers, up to four (4): 2400-SV107-1 to SV107-4.					
24f	2400	SV102	Charges	R / R	
FL 24f Guidelines for CMS-1500: Indicate you're usual and customary charges, **in the unshaded area,** for each service listed. Charges must not be higher than fees charged to private pay patients. **In the shaded area**, enter the third party liability payment. 837P Guidelines: Total charge amount for this service line. Zero '0' is an acceptable value.					
24g	2400	SV104	Units	R / R	
FL 24g Guidelines for CMS-1500: Enter **in the unshaded area,** the appropriate number of units. Be sure that span-billed daily hospital visits equal the units in this field. Use whole numbers only. 837P Guidelines: Units are sent within the 2400-SV104. If the units within SV104=Minutes, the value of 'MJ' is sent within SV103. If the units within SV104=Units, the value of 'UN' is sent within the SV103.					
24h	2400 2300	SV111 SV112 CRC	EPSDT Family Planning	C / C	
FL 24h Guidelines for CMS-1500: TITLE: EPSDT/Family Plan [lines 1–6] For Early & Periodic Screening, Diagnosis, and Treatment related services, enter the response in the shaded portion of the field as follows: • If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only. If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A 'Y' or 'N' response is not entered with the code.) The two character code is right justified in the shaded area of the field. The following codes for EPSDT are used in 5010A1: 1. AV - Available – Not Used (Patient refused referral.)					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
2. S2 - Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) 3. ST - New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) 4. NU - Not Used (Used when no EPSDT patient referral was given.) If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field. The "EPSDT/Family Plan" identifies certain services that may be covered under some state plans. This field allows for the entry of one character in the unshaded area. <u>837P Guidelines:</u> • EPSDT Indicator, if applicable: 2400-SV111='Y'. • Family Planning Indicator, if applicable: 2400-SV112='Y'. Reason Code(s) for EPSDT, up to three (3), if applicable: • 2300-CRC01='ZZ' • 2300-CRC02='N' or 'Y' • 2300-CRC03 to CRC05='AU', 'NU', 'S2', or 'ST'.					
24i	2420A	NM1 PRV REF	ID Qual	C / C	
24j			Rendering provider ID		
<u>FL 24i & 24j Guidelines for CMS-1500:</u> Enter the individual rendering (treating) provider's qualifier code **in the shaded area** of form locator 24i. The rendering provider's other ID number is reported in form locator 24j in the shaded area. Enter the rendering provider's ID number only when it is different from the pay-to provider number that is entered in form locator 33a or 33b. If entering the rendering provider's Medicaid provider number, enter qualifier code 1D and Medicaid provider number in the **non-shaded area** in form locator 24i & 24j**.** If entering the rendering provider's NPI and the NPI is mapped to a taxonomy code that is needed to identify the provider in the Georgia Medicaid claims processing system, enter qualifier code ZZ and the taxonomy code in the shaded area of form locator 24j. Valid Qualifier Codes: • 1D = Medicaid provider number • ZZ = provider taxonomy number					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
• 1G = UPIN • 0B = physician license number <u>837P Guidelines:</u> See mapping below.					
	2420A	NM103	Detail Level: Rendering Provider Last Name	C	<u>837P:</u> NM101=82 NM102=1 (Must not equal 2310B if present)
	2420A	NM104	Detail Level: Rendering Provider First Name	C	<u>837P:</u> Must not equal 2310B if present
	2420A	NM109	Detail Level: Rendering Provider NPI	C	<u>837P:</u> NM108=XX (Must not equal 2310B if present)
	2420A	PRV03	Detail Level: Rendering Provider Taxonomy Code	C	<u>837P:</u> PRV01=PE PRV02=PXC (Must not equal 2310B if present)
	2420A	REF02	Detail Level: Rendering Provider 'Other Identifier'	C	
<u>837P Guidelines:</u> 2420A REF01 valid values: • 'G2', if REF02=Medicaid Provider Number • '1G', if REF02=UPIN • '0B', if REF02=Physician License Number					
24k	N/A	N/A	Reserved for Local Use	N/A	<u>CMS-1500:</u> Leave Blank
Claim Level Information					
25	2010AA	REF02	Federal Tax I.D. Number	R / R	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
FL 25 Guidelines for CMS-1500: Enter Social Security number (SSN) or Employee Identification number (EIN). 837P Guidelines: Billing Provider, Rendering or Service Facility Tax ID or SSN. • REF01='SY', if REF02=SSN • REF01='EI', if REF02=Tax ID • If, Billing Provider is present, where no Rendering Provider or Service Facility is present, value will equal Billing Provider Tax ID or SSN. • If, Billing Provider is present and Rendering Provider is present, where no Service Facility is present, value will equal Rendering Provider Tax ID or SSN. • If, Billing Provider, Rendering Provider and Service Facility are present, value will equal Rendering Provider Tax ID or SSN. • If, Billing Provider and Service Facility Provider is present, where no Rendering Provider is present, value will equal Billing Provider Tax ID.					
26	2300	CLM01	Patient Account Number	C / R	CMS-1500: Enter the patient's record number used internally by your office.
27	2300	CLM07	Accept Assignment	R / R	
FL 27 Guidelines for CMS-1500: Billing Medicaid indicates acceptance of assignment. 837P Guidelines: • A=Assigned • B=Assignment Lab Services Only • C=Not Assigned					
28	2300	CLM02	Total Charge	R / R	
FL 28 Guidelines for CMS-1500: Enter the sum of all charges entered in form locator 24f, lines 1-6. 837P Guidelines: Sum of all details (2400-SV102).					
29	2320	AMT02	Amount Paid	C / C	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
FL 29 Guidelines for CMS-1500: Enter any amount paid by an insurance company or other sources known at the time of submission. **Do not enter Medicaid co-payment amount. Do not enter Medicare payments**. 837P Guidelines: AMT01= D					
30	N/A	N/A	Reserved for NUCC Use	N/A	
FL 30 Guidelines for CMS-1500: This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.					
31	N/A	N/A	Signature of physician or supplier	R	
FL 31 Guidelines for CMS-1500: Provider must sign (or signature stamp) and provide degrees or credentials. Enter the current date. **Note**: Unsigned invoice/claims forms cannot be accepted for processing.					
32	2310C	NM1 N3 N4	Name and address of facility	R / C	
FL 32 Guidelines for CMS-1500: Service Facility Location Information. Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider. Enter the name and address information in the following format: • 1st Line – Name • 2nd Line – Address • 3rd Line – City, State and ZIP Code Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code, including the hyphen. If reporting a foreign address, contact payer for specific reporting instructions.					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
The name and address of facility where services were rendered identifies the site where service(s) were provided. This field allows for the entry of three lines of 26 characters each in the Service Facility Location. 837P Guidelines: See mapping below.					
	2310C	NM103	Service Facility Name	C	837P: NM101=77 NM102=2
	2310C	N301	Service Facility Address Line 1	C	
	2310C	N302	Service Facility Address Line 2	C	
	2310C	N401	Service Facility City	C	
	2310C	N402	Service Facility State	C	
	2310C	N403	Service Facility Zip Code	C	837P: If, Service Facility Zip Code is present, it must contain the full 9 digits. 5 + 4 digit postal code (exclude punctuation and blanks).
32a	2310C	NM109	NPI#	C / C	837P: NM108=XX
FL 32a Guidelines for CMS-1500: Enter the NPI number of the service facility location in 32a. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI. The NPI number refers to the HIPAA National Provider Identifier number. This field allows for the entry of 10 characters.					
32b	2310C	REF02	Other ID	R / C	837P: REF01=0B REF01=G2

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
					REF01=LU
FL 32b Guidelines for CMS-1500: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC defines the following qualifiers used in 5010A1: • 0B State License Number • G2 Provider Commercial Number • LU Location Number The non-NPI ID number of the service facility is the payer assigned unique identifier of the facility. This field allows for the entry of one to four characters in 32b.					
33	2010AA	NM1 N3 N4	Billing Provider Info and Phone Number	R / R	
FL 33 Guidelines for CMS-1500: 1st Line: Name of the Payee provider as it appears in the Gainwell Technologies system 2nd Line: Address 3rd Line: City, State, and ZIP Code (include ZIP+4) and phone number. 837P Guidelines: See mapping below.					
	2010AA	NM103	Billing Provider Last Name or Organization	R	837P: NM101=85 NM102=1 (Person); 2 (Non-Person)
	2010AA	NM104	Billing Provider First Name or Organization	C	837P: Required if NM102=1
	2010AA	N301	Billing Provider Address Line 1	R	
	2010AA	N302	Billing Provider Address Line 2	C	837P: If, applicable
	2010AA	N401	Billing Provider City	R	

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
	2010AA	N402	Billing Provider State	R	
	2010AA	N403	Billing Provider Zip Code	R	837P: Must contain the full 9 digits. 5 + 4 digit postal code (exclude punctuation and blanks).
	1000A 2010AA	PER	Billing Provider Phone Number	C	
837P Guidelines: • 1000A PER is required. Information contained within the 1000A = EDI Submitter Contact Information. o PER01 = IC o PER02 = Contact Name o PER03 = TE o PER04 = Contact Telephone Number • 2010AA PER is Situational. If, present it must not equal the information that is sent within the 1000A PER. o PER01 = IC o PER02 = Billing Provider Contact Name o PER03 = TE o PER04 = Billing Provider Contact Telephone Number					
33a	2010AA	NM109	Billing Provider NPI#	R / R	
FL 33a Guidelines for CMS-1500: Enter the NPI number of the billing provider in 33a. The NPI number refers to the HIPAA National Provider Identifier number. This field allows for the entry of 10 characters. 837P Guidelines: NM108=XX					
33b	2010BB	REF02	Billing Provider Medicaid number	R / C	
FL 33b Guidelines for CMS-1500: Enter Billing Provider Medicaid number.					

1500 Form Locator	837 Loop ID	837 Segment/ Data Element	Field Name	Required Information	Guidelines
837P Guidelines: Provider Medicaid Number should only be sent for Atypical Providers on the 837P. Typical providers are required to send NPI# as documented in FL 33a. • REF01=G2					

4.7.1 Exception Dates of Service Requirements

Please review the following Provider Contract, formerly known as Category of Service (COS), before completing the CMS-1500 form. This information explains the DOS requirements necessary when completing the CMS-1500 form:

- **Physician**, **Podiatry**, **Advanced Nurse Practitioner**, **Nurse-Midwifery**, **and Vision programs** allow the DOS to span only if the date span falls within the same calendar year, December 31 through January 1, or the state fiscal year, June 30 through July 1.
- **Service Options Using Resources in Community Environments (SOURCE)** providers are not allowed to span into another month. Bill only one month of service per detail.
- **Community Care Services Program (CCSP)** providers must bill one month per claim. Overlapping one month to the next is not allowed.
- **Children Intervention Services (CIS)** and **Children Intervention School Services (CISS)** providers are not allowed to span their DOS.
- **Health Check** providers are not allowed to span their DOS.
- **Children At Risk Targeted Case Management** providers are allowed to span dates, but the provider bills the From DOS and To DOS as the last day of every month.
- **Georgia Pediatric Program (GAPP)** providers are not allowed to span their DOS.
- **NOW Waiver** and **COMP Waiver** providers are allowed to span within the month or for a month. Do not span from one month to the next.
- **Ambulance Services** providers are not allowed to span their DOS.
- **Home Health** providers are allowed to span DOS from one month to another except at the end of a calendar year.
- **Independent Care Waiver Program (ICWP)** providers are not allowed to span within the month or for a month. DOS cannot cross over from one month to the next

4.7.2 Place of Service Codes (POS)

POS Code	POS Description
03	School – A school facility where a member receives a Medicaid service.
11	Office – Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, intermediate care facility (ICF), or mobile van where the health professional routinely provides health examination, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Patient's Home – Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility – Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home – Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.
21	Inpatient Hospital – A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non surgical) and rehabilitation services, by or under the supervision of physicians, to patients admitted for a variety of medical conditions.
22	Outpatient Hospital – A portion of a hospital that provides diagnostic, therapeutic (both surgical and non surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital – A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided on a 24-hour basis.
24	Ambulatory Surgical Center - A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center – A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery and immediate postpartum care as well as immediate care of newborn infants.
31	Skilled Nursing Facility - A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital.

POS Code	POS Description
32	Nursing Facility – A facility that primarily provides residents with skilled nursing care and related services for rehabilitation of an injured, disabled, or sick person; or on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility – A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice - A facility other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. Note: This place of service can only be used when the actual service is performed in a hospice facility. If a hospice patient receives services in a setting other than a hospice facility, then the specific location for that service must be used.
49	Independent Clinic – A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center - A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. This place of service code is only used for Medicare crossover billing
53	Community Mental Health Center - A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	Intermediate Care Facility for the Developmentally Disabled (IFC-DD) - A facility that primarily provides health-related care and services above the level of custodial care to developmentally disabled individuals, but does not provide the level of care or treatment available in a hospital or a skilled nursing facility.
55	Residential Substance Abuse Treatment Facility - A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
57	Non-residential Substance Abuse Treatment Facility - A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and

POS Code	POS Description
	counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
62	Comprehensive Outpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities.
65	End Stage Renal Disease Treatment Facility - A facility other than a hospital, which provides dialysis treatment, and maintenance or training to patients or caregivers.
71	State or Local Public Health Clinic - A facility maintained by either state or local health departments that provides ambulatory primary care under the general direction of a physician.
72	Rural Health Clinic - A certified facility located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory - A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
99	Other Unlisted Facility – Other service facilities not identified above.

4.8 Electronic Claim Submission

4.8.1 Introduction

Submitting Medicaid claims using electronic media offers the advantage of speed and accuracy in processing. Providers may submit electronic claims themselves or choose a trading partner or clearinghouse that offers electronic claim submission services.

4.8.2 Benefits

The benefits of electronic claims submission include:

1. Increased speed of claims payments; seven days in some cases
2. Correct data entry errors immediately, avoiding mailing time and costs
3. Eliminate the cost and inconvenience of claims paperwork
4. Reduce office space required for storing claim forms, envelopes, and so on
5. Decrease clerical labor costs
6. Automate the office for a more efficient operation

4.8.3 How to Participate in Electronic Claims Submission

In order to submit electronic claims, a provider and/or their representative/billing agent must be authorized. The authorization process requires the submission of the

Electronic Data Interchange (EDI) Agreement Form, issuance of a trading partner ID, and testing to ensure the trading partner can accurately submit transactions.

The EDI Services team is available each weekday (excluding state holidays), Monday through Friday from 8:00 a.m. - 5:00 p.m., Eastern Standard Time at 1-877-261-8785.

4.8.4 Paperless Initiatives

Georgia Medicaid launched a paperless initiative that began September 1, 2014, and will be implemented over a 10-month period into early 2015. Provider notifications will be published to alert enrolled providers of the transition.

The Paperless Initiative will enhance providers' experiences for online-only provider enrollment and electronic submission of claims filing for all claims types and provider types. Paper submissions will be accepted on or after May 1, 2015, except for Out-of-State claims for providers, filing appeals, and disbursement of payments to providers. The types of claims that will be submitted electronically and/or the Web Portal are the DMA 520 Form (Provider Inquiry), Medicare and Medicare Advantage Claims, Institutional claims, and Inpatient Part B only claims. Any claims submitted on paper after May 1, 2015, will be returned to the provider with a letter stating that the claims must be submitted electronically.

GA Medicaid is updating its manual and paper processes to expedite the handling of Georgia Medicaid claims through a 24/7 depository for all claims, electronic remittance advices (no mailed copies). This will allow for a more timely filing of claims and appeals for easy access and follow-up. In addition, this process will increase efficiency and reduce administrative burden and overhead cost for our providers, improve cash flow, diminish the downtime of mail delivery, and result in a quicker and more secure transmission of payments through an Electronic Fund Transfer (EFT) process.

Post Office Boxes

There will be some Gainwell Technologies' post office boxes that will remain open and not closed under the Paperless Initiative. The following post office boxes are to be used for the specific mailed documents to Gainwell Technologies in Tucker, GA 30085.

- PO Box 105200 – Member and Provider Correspondence
- PO Box 105208 – Retroactive Eligibility Claims, Out of State Claims (Over 50 miles beyond the GA border), and Outlier Documentation
- PO Box 105209 – Miscellaneous Non-Claim documents and Business Reply mail such as returned EOMBS and MSQs

All paper claims, appeals, certain forms, prior authorization/pre-certifications, and provider enrollment documents are to be submitted as instructed (electronic or faxed). The Georgia Medicaid Information Management System (GAMMIS) secure Web Portal is found at www.mmis.georgia.gov.

On or after May 1, 2015, no paper or hard copy claims or paper appeals or prior authorization requests beyond GA Medicaid's policy deadlines will be accepted in GAMMIS.

4.8.5 Free Software and Electronic Claims Submissions Options

DCH strongly encourages electronic submission of claims and most other transactions.

Gainwell Technologies supports several types of data transport depending upon the submitters needs. Providers and their representatives submit and receive data using: Web Portal, Provider Electronic Solutions (PES) software, Remote Access Server (RAS), diskette/CD-ROM/tape/DVD (in special situations only), Secure File Transfer Protocol (SFTP). In addition, vendors may enroll as Value Added Networks (VANs) for (fee-based) interactive eligibility transactions.

The following sections provide an overview for each of the EDI submission methods.

4.9 Web Portal

Data is transmitted using the secure Web Portal. Submission options are Direct Data Entry (DDE) and Batch. The MMIS Web Portal (as a single gateway) is an important tool providing general and program specific information and links to other programs, applications, related agencies and resources. The Web Portal has both secure and non-secure areas.

The Web Portal is available to customers 24 hours per day, seven days per week (except during pre-scheduled system maintenance). To access the Web Portal, visit www.mmis.georgia.gov. For more information concerning Web Portal usage and registration, see the Provider Web Portal Navigational Manual which is located on our website www.mmis.georgia.gov on the Provider Manuals page found under the Provider Information menu.

4.9.1 Web Portal Reference Updates

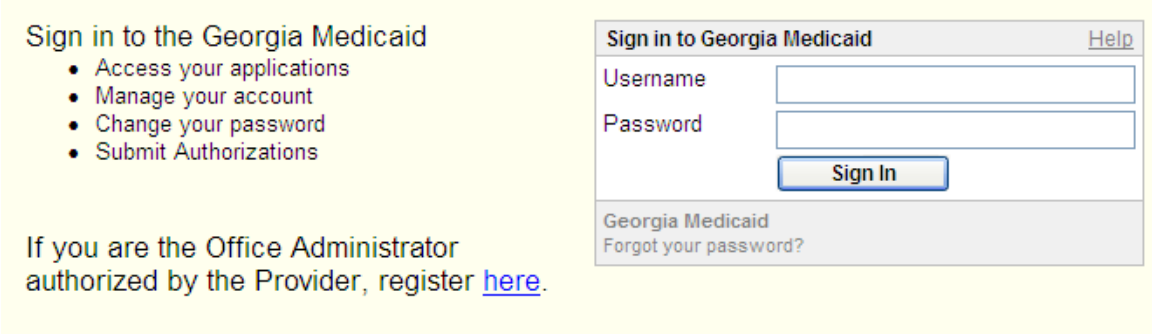
Changes regarding EDI issues or compliance edits are posted to the Web Portal by the EDI Services or EDI Systems team to alert all providers, trading partners, and third-parties of any issues that may impact electronic production of claims and other critical system maintenance issues, and future enhancements (for example, implementation of International Classification of Diseases-10 (10th revision)-Clinical Modification (ICD-10CM) diagnosis and procedure codes).

4.9.2 Web Portal Password Management

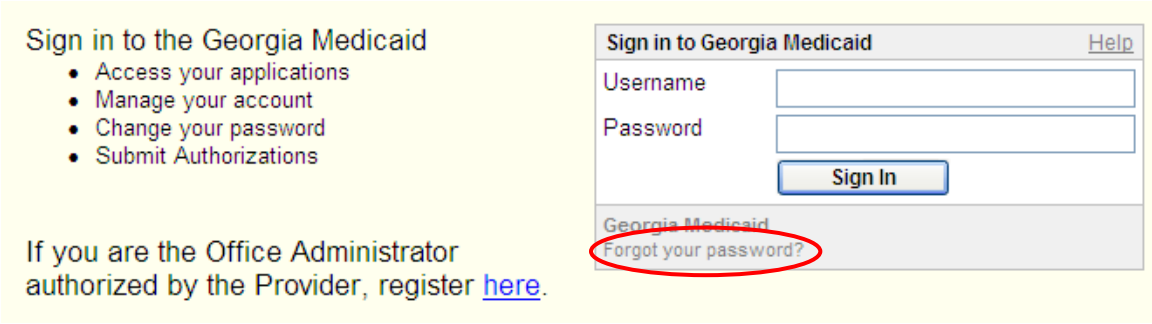
Step 1: Access the public Web Portal at: www.mmis.georgia.gov

Step 2: Click the "Login" button on the public Web Portal Home page.

Step 3: Enter the **Username** and **Password** for the registered account you wish to act as and click "Sign In."

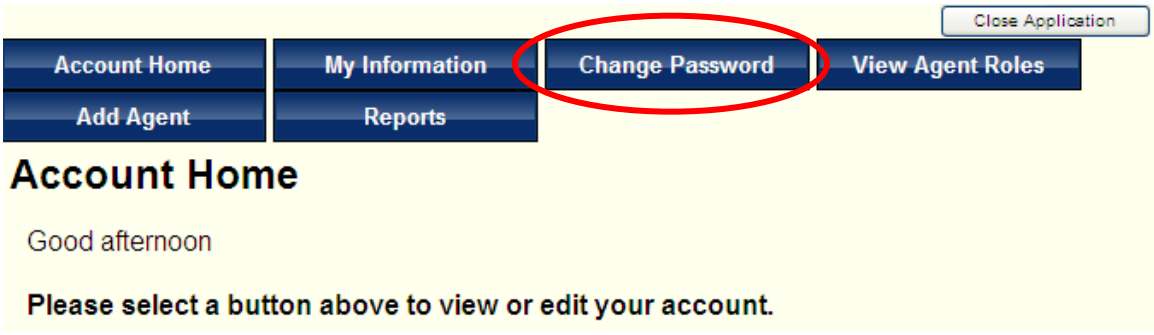


Please Note: If the password has been forgotten or has already expired, click the "Forgot your password?" link on the log in page and enter the e-mail address and user name created during the registration process. If the username has been misplaced, please navigate to the pubic Web Portal (www.mmis.georgia.gov) and click the Provider Information menu for methods on contacting EDI Services for further assistance.

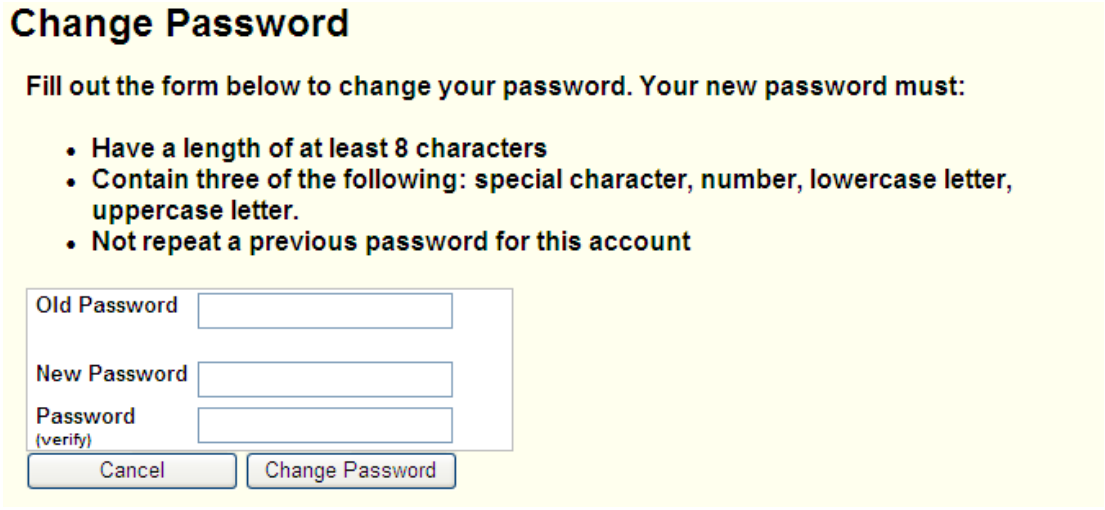


Step 4: If the log in was successful, click "MEUPS Account Management."

Step 5: Click "Change Password."



Step 6: Complete the fields displayed and click "Change Password." Make sure your new password conforms to the format indicated on the screen.



4.9.3 Web Portal Support

In addition to providing EDI support, the EDI Services team will also assist with all Web Portal technical support questions including all Web Portal problems that members, providers, and provider office administrators/billing agents may have accessing the Web Portal, and registering for the Web Portal.

Note: The Provider Services Contact Center assists all providers with non-EDI issues regarding the Web Portal, including how to navigate the Web Portal, how to enter/adjust a claim or enter a prior authorization/referral on the Web Portal, where to locate specific information, forms, and provider manuals.

The Member Services Contact Center assists all members with non-EDI and non-technical issues regarding the Web Portal, including Web Portal password resets, where to locate pamphlets, forms, and coverage limitations.

4.9.4 Direct Data Entry (DDE) Transmissions Using the Web Portal

Direct Data Entry (DDE) allows providers to submit individual transactions one transaction at a time, with no limitations on the number of transactions that can be submitted using the Web Portal.

Note: DDE is not available for NCPDP (Encounters).

4.9.5 Upload Batch Transmissions Using the Web Portal

A trading partner has the option to upload HIPAA based transactions such as a batch of claims or eligibility request or non-HIPAA transactions via the Web Portal for processing in the MMIS. All claims must be in the HIPAA compliant format (i.e. X12 837-Professional, 837-Institutional, or 837-Dental). A batch may contain one claim transaction or many.

Trading partners log on to the secure Web Portal, navigate to the Trade Files menu option, and upload a file. The following screen displays:

The file is validated against the Georgia Medicaid Companion Guides and the user receives one acceptance or reject report in response to the 270, 276 or 834 input transactions, TA1 or 999. The user receives one or a combination of two different acceptance and rejection reports in response to the 837 transactions, TA1, 824, or 277U.

1. TA1 - The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

2. 999 – The X12N 999 contains accept or reject information for X12N 270, 276 and 834 input files. If the file contained syntactical errors, the segments and elements where the error occurred are reported on the rejected 999. If no errors are found, a 999 transaction is sent to acknowledge receipt and acceptance of the transaction.

3. 824 - The X12N 824 contains accept or reject information for X12N 837 input files. If the input file contained errors, the segments and data elements where the error occurred are reported on the 824. The 824 will have an action code of "RU" if the incoming file was partially accepted, "U" if the incoming file was entirely rejected or "WQ" if the incoming file was entirely accepted.

4. 277U – The X12N 277U is returned for all suspended claims. In addition, the 277U is used to communicate claims where a provider record cannot be determined (primarily related to NPI mapping activities).

If the file passes compliance, it is sent to GAMMIS for processing.

Notes regarding file specifications:

1. EDI allows upload and download of zip files. However, only one file per zip is allowed.

2. EDI does not require any specific file extensions. This includes files without any extension.

3. EDI allows up to a two-gigabyte file to be uploaded.

4.9.6 Download Transmission Reports and ERA Using the Web Portal

Providers log on to the secure Web Portal, navigate to the Trade Files menu option, and download a file. The type of file is displayed under 'document type'. This includes all reports, HIPAA transactions (i.e. 820's and 835's) and electronic remittance advices. Additionally, authorized users can download non-HIPAA files.

Note: Agent delegation may be required of the provider to add a trading partner or third-party agent to be able to act as a delegate on the provider's behalf to retrieve these reports.

4.9.7 Remote Access Server (RAS) Dial-Up Transmission

The RAS enables providers to access all options of the secure Web portal without the use of an Internet Service Provider. This option is available to users who do not have an existing Internet connection. The RAS server typically supports users that need a dial-up option. Trading partner data transmitted using the RAS can be transmitted the same as the Internet secure site using DDE or upload batch transactions.

After the connection is established, the landing page is presented. A user either logs on and is presented with their secure provider page, or selects 'register' if they are a first-time user.

Once logged on, the user will have access to the various secure Web portal options, including File Upload and File Download for EDI transactions.

4.10 Secure File Transfer Protocol (SFTP)

SFTP uses Secure Shell (SSH) to encrypt and then securely transmit data across a potentially unsecured connection. Functionally SFTP (required) is similar to FTP, but offers protection to sensitive data. Secure Shell or SSH is a network protocol that allows data to be exchanged using a secure channel between two networked devices.

This option allows provider, vendors, and all other trading partners to transfer claim files to Gainwell Technologies using the secure file transfer protocol server. Trading partners must notify us specifically if wishing to use this transmission method to transmit files.

Gainwell Technologies requires that the SFTP submitters send their public key and Gainwell Technologies exchanges its public key with the submitter for encryption purposes. Gainwell Technologies will setup a username and password for the submitter to access the server. Along with using SFTP, Gainwell Technologies

requires that each file being transmitted over SFTP should be encrypted using PGP public-private key encryption because PHI data sits on DMZ zone for certain period. To achieve this Gainwell Technologies requires that the SFTP submitters exchange their PGP public key with Gainwell Technologies.

Note: Additional detailed information on the panels, steps, and processes using the SFTP server can be found in the SFTP Setup and Data Transfer Requirements guide. Users wishing to submit via SFTP should be sending files larger than 20MB but not greater than the 50MB file size limit (must submit batch uploads via the Web Portal, which allows files up to 20MB). SFTP users must complete a separate SFTP Authorization Form and then faxed to the EDI Services Team. This is upon completion of the EDI Enrollment Agreement Form and successful EDI testing.

4.11 Provider Electronic Solutions (PES)

Gainwell Technologies provides free software called Provider Electronic Solutions (PES) for the submission of claim transactions. The system PC minimum requirements for PES are Windows 2000 or higher. This software complies with HIPAA requirements and is available to all providers who wish to submit claims electronically. The HIPAA-ready manual available for billing Georgia Medicaid using PES include:

1. 837 Professional

2. 837 Institutional (Nursing Home, Inpatient, and Outpatient Hospital)

3. 837 Dental

Georgia Medicaid providers can download a copy of the PES software from the Web Portal. A user manual, installation guide, and the initial password to access the PES application comes with the software. The EDI Services team will assist and answer any immediate questions or refer providers needing additional training to the Provider Relations team.

Note: For additional information regarding specific PES procedures and functionality, please locate the PES Manual located on our website at www.mmis.georgia.gov under EDI, Software and Manuals. The PES manual contains information for the following services: Professional Claims (CMS-1500), Dental claims, Nursing Home claims and Inpatient and Outpatient Institutional (UB-04) claims. Refer to Section 2 regarding instructions on downloading and installing PES along with the PC system requirements. This manual will also include panels and billing instructions.

4.12 Value Added Networks (VANS)

VANs support interactive transactions for established vendors. VANs sign contracts with the State and set up unique VAN-specific communication arrangements with Gainwell Technologies.

4.13 How to submit a Professional Claim on the Web Portal

The Professional Claim page allows providers, payees and billing agents to view professional claims which have processed with Georgia Medicaid. Rendering providers and billing agents acting as rendering providers may use the professional claim page to submit a claim and/or adjust or void a paid claim. This includes the

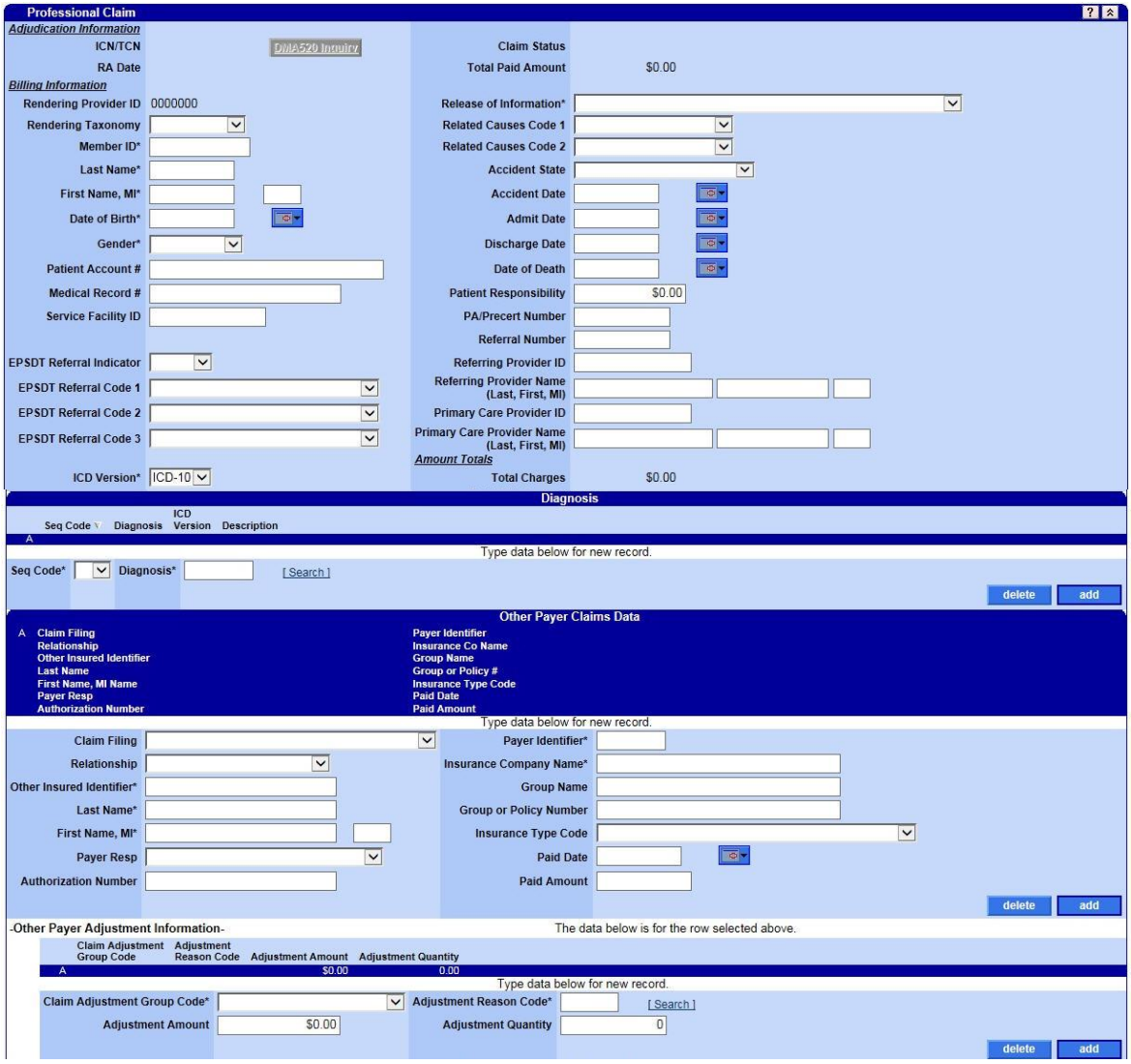
ability to copy a paid claim or modify a denied claim that can be sent to Georgia Medicaid and reprocessed as a new claim. Payees and billing agents acting as payees will be restricted to read-only access.

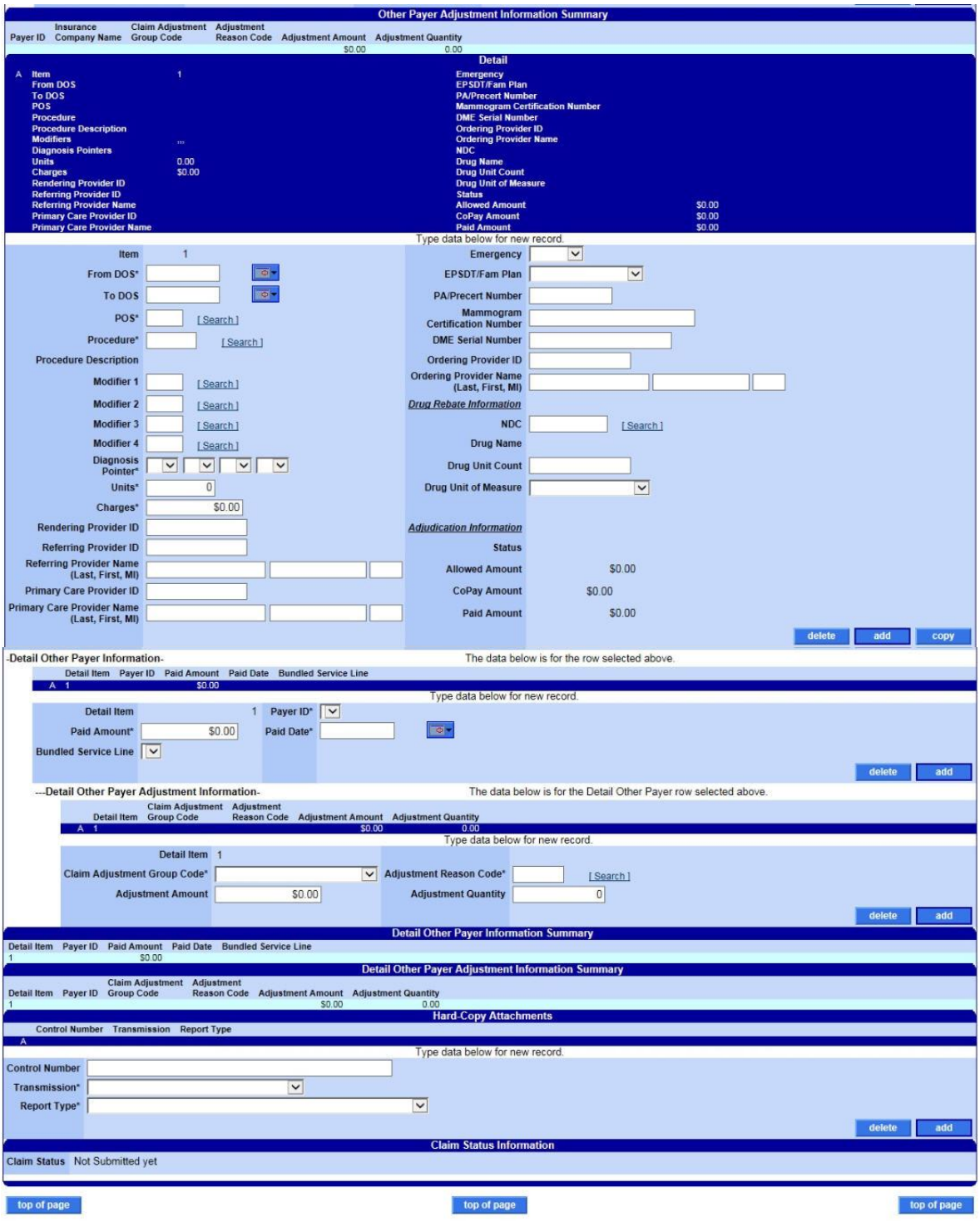
Attachments can be included as part of the Web submission process. The ability to upload an electronic attachment is provided once the user submits the claim with a transmission type of electronic upload or file transfer. If the response indicates the claim will be suspended for attachments, the upload ability will be provided for the user to attach their electronic file with the claim.

Providers and billing agents will automatically be restricted to viewing claims that have been processed with their provider ID as the rendering or payee provider. Billing agents may use the Switch Provider page to select and navigate on the Web Portal using a different provider ID account to view the appropriate claim.

Navigational Path: Claims – New Professional Claim

Step	Action	Result
Start from the secured Claims menu.		
1	Select the New Professional Claim submenu.	The Professional Claim page displays.


Professional Claim
Adjudication Information
ICN/TCN
RA Date
Billing Information
Rendering Provider ID
0000000
Rendering Taxonomy
Member ID*
Last Name*
First Name, MI*
Date of Birth*
Gender*
Patient Account #
Medical Record #
Service Facility ID
EPSDT Referral Indicator
EPSDT Referral Code 1
EPSDT Referral Code 2
EPSDT Referral Code 3
ICD Version*
ICD-10
Claim Status
Total Paid Amount
$0.00
Release of Information*
Related Causes Code 1
Related Causes Code 2
Accident State
Accident Date
Admit Date
Discharge Date
Date of Death
Patient Responsibility
$0.00
PA/Precert Number
Referral Number
Referring Provider ID
Referring Provider Name (Last, First, MI)
Primary Care Provider ID
Primary Care Provider Name (Last, First, MI)
Amount Totals
Total Charges
$0.00
Diagnosis
Seq Code
Diagnosis
ICD Version
Description
Type data below for new record.
Seq Code*
Diagnosis*
[Search]
delete
add
Other Payer Claims Data
Claim Filing
Relationship
Other Insured Identifier
Last Name
First Name, MI Name
Payer Resp
Authorization Number
Payer Identifier
Insurance Co Name
Group Name
Group or Policy #
Insurance Type Code
Paid Date
Paid Amount
Type data below for new record.
Claim Filing
Relationship
Other Insured Identifier*
Last Name*
First Name, MI*
Payer Resp
Authorization Number
Payer Identifier*
Insurance Company Name*
Group Name
Group or Policy Number
Insurance Type Code
Paid Date
Paid Amount
delete
add
-Other Payer Adjustment Information-
The data below is for the row selected above.
Claim Adjustment Group Code
Adjustment Reason Code
Adjustment Amount
Adjustment Quantity
$0.00
0.00
Type data below for new record.
Claim Adjustment Group Code*
Adjustment Amount
$0.00
Adjustment Reason Code*
[Search]
Adjustment Quantity
0
delete
add


Other Payer Adjustment Information Summary
Payer ID
Insurance Company Name
Claim Adjustment Group Code
Adjustment Reason Code
Adjustment Amount
Adjustment Quantity
$0.00
0.00
Detail
A Item 1
From DOS
To DOS
POS
Procedure
Procedure Description
Modifiers
Diagnosis Pointers
Units 0.00
Charges $0.00
Rendering Provider ID
Referring Provider ID
Referring Provider Name
Primary Care Provider ID
Primary Care Provider Name
Emergency
EPSDT/Fam Plan
PA/Precert Number
Mammogram Certification Number
DME Serial Number
Ordering Provider ID
Ordering Provider Name
NDC
Drug Name
Drug Unit Count
Drug Unit of Measure
Status
Allowed Amount $0.00
CoPay Amount $0.00
Paid Amount $0.00
Type data below for new record.
Item 1
From DOS*
To DOS
POS* [Search]
Procedure* [Search]
Procedure Description
Modifier 1 [Search]
Modifier 2 [Search]
Modifier 3 [Search]
Modifier 4 [Search]
Diagnosis Pointer*
Units* 0
Charges* $0.00
Rendering Provider ID
Referring Provider ID
Referring Provider Name (Last, First, MI)
Primary Care Provider ID
Primary Care Provider Name (Last, First, MI)
Emergency
EPSDT/Fam Plan
PA/Precert Number
Mammogram Certification Number
DME Serial Number
Ordering Provider ID
Ordering Provider Name (Last, First, MI)
Drug Rebate Information
NDC [Search]
Drug Name
Drug Unit Count
Drug Unit of Measure
Adjudication Information
Status
Allowed Amount $0.00
CoPay Amount $0.00
Paid Amount $0.00
delete
add
copy
-Detail Other Payer Information-
The data below is for the row selected above.
Detail Item
Payer ID
Paid Amount
Paid Date
Bundled Service Line
A 1 $0.00
Type data below for new record.
Detail Item 1
Payer ID*
Paid Amount* $0.00
Paid Date*
Bundled Service Line
delete
add
---Detail Other Payer Adjustment Information-
The data below is for the Detail Other Payer row selected above.
Detail Item
Claim Adjustment Group Code
Adjustment Reason Code
Adjustment Amount
Adjustment Quantity
A 1 $0.00 0.00
Type data below for new record.
Detail Item 1
Claim Adjustment Group Code*
Adjustment Reason Code* [Search]
Adjustment Amount $0.00
Adjustment Quantity 0
delete
add
Detail Other Payer Information Summary
Detail Item
Payer ID
Paid Amount
Paid Date
Bundled Service Line
1 $0.00
Detail Other Payer Adjustment Information Summary
Detail Item
Payer ID
Claim Adjustment Group Code
Adjustment Reason Code
Adjustment Amount
Adjustment Quantity
1 $0.00 0.00
Hard-Copy Attachments
Control Number
Transmission
Report Type
A
Type data below for new record.
Control Number
Transmission*
Report Type*
delete
add
Claim Status Information
Claim Status Not Submitted yet
top of page
top of page
top of page

Field Descriptions

Field	Description
Accident Date	Displays the date the accident occurred.
Accident State	Displays the state where the accident occurred.
add	This button is used to add data to a panel.
adjust	This button submits adjustments for a paid claim.
Adjustment Amount	Displays the adjustment amount.
Adjustment Quantity	Displays the adjustment quantity.
Adjustment Reason Code	Displays the adjustment reason code. The following values are used in relation to Medicare crossovers: 1 = Deductible Amount, 2 = Coinsurance Amount, 3 = HMO Subcopay Amount, 66 = Blood Deductible, 122 = Psychiatric Amount. For a complete listing of HIPAA Adjustment Reason codes, navigate to www.wpc-edi.com.
Admit Date	Displays the date on which the member was admitted to the inpatient hospital for which services are being billed.
Allowed Amount	Displays the amount Georgia Medicaid approved to pay for services provided to a member. (Read-Only)
Authorization Number	Displays the prior authorization number issued by the third party.
Bundled Service Line	Displays the detail to be bundled together.
cancel	This button cancels the current operation and discards any changes.
Charges	Displays the usual and customary charge for the service provided.

Field	Description
Claim Adjustment Group Code	Displays the claim adjustment group code. For Medicare Coinsurance and Deductible information, ensure the value selected reflects "Patient Responsibility".
Claim Filing	Displays the type claim filing for the other insurance.
Claim ICN	Displays the internal control number which uniquely identifies a claim. (Read-Only)
Claim Status	Displays the status of the claim. (Read-Only)
Code	Displays the explanation of benefits code. (Read-Only)
Control Number	Displays the number assigned by the user to the attachment or paperwork for identification purposes.
CoPay Amount	Displays the copay amount for service provided. (Read-Only)
copy	This button creates a new detail from the selected detail.
copy claim	This button creates a new claim from the current claim.
Date Adjusted	Displays the date the claim was adjusted. (Read-Only)
Date of Birth	Displays the date of birth of the member.
Date of Death	Displays the date of death of the member.
delete	This button is used to delete data from a panel.
Denied Date	Displays the date the claim was denied. A zero date indicates that the claim has been adjudicated but has not been processed against a remittance advice. Field appears in place of the RA Paid Date when the header claim status has been denied. (Read-Only)
Description	Displays the explanation of benefits description. (Read-Only)
Detail Item	Displays the Detail number. (Read-Only)
Detail Number	Displays the line item detail number of the claim. (Read-Only)
Diagnosis	Displays the diagnosis code that identifies the medical classification of a disease or condition.
Diagnosis Pointer	Indicates which diagnosis (or diagnoses) for which services were provided. If a diagnosis code was entered, select the matching sequence number as seen on the diagnosis panel to indicate which diagnosis the procedure is a result of.
Discharge Date	Displays the date on which the member was discharged from the inpatient hospital for which services are being billed.

Field	Description
DME Serial Number	Displays the durable medical equipment serial number.
Drug Name	Displays the name for the NDC.
Drug Unit Count	Displays the number of drug units billed for the service.
Drug Unit of Measure	Displays the code that indicates the type of measurement for the drug units indicated.
Emergency	Displays whether service was provided as a result of an emergency situation.
EPSDT Referral Code 1	Displays the primary condition code related to the EPSDT (Health Check) Referral.
EPSDT Referral Code 2	Displays the secondary condition code related to the EPSDT (Health Check) Referral.
EPSDT Referral Code 3	Displays the tertiary condition code related to the EPSDT (Health Check) Referral.
EPSDT Referral Indicator	Displays whether the service is related to an EPSDT (Health Check) Referral.
EPSDT/Fam Plan	Displays if claim is related to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or family planning services.
First Name, MI	Displays the first name and middle initial of the member. Middle Initial is an optional field.
First Name, MI [TPL]	Displays the first name and middle initial of the subscriber for the insurance plan.
From DOS	Displays the beginning date on which service was provided.
Gender	Displays the gender of the member.
Group Name	Displays the group name for the other insurance by which the member is assigned.
Group or Policy Number	Displays the group or policy number that uniquely identifies the member's assignment to the other insurance.
ICD Version	Displays the version of the ICD value. (Read-Only)
ICN	Displays the internal control number which uniquely identifies a claim. Clicking the ICN from the adjustment information panel will allow authorized providers to view the claim in detail. (Read-Only)

Field	Description
ICN/TCN	Displays either the internal control number or the cross reference between claims from the old system to the new system, identified by a TCN. (Read-Only)
Insurance Company Name	Displays the name of the other insurance plan or the name of the company issuing the insurance, including Medicare, by which the member is assigned.
Insurance Type Code	Displays the code identifying the type of insurance policy for the other insurance.
Item	Displays the detail line number. (Read-Only)
Last Name	Displays the last name of the member.
Last Name [TPL]	Displays the last name of the subscriber for the insurance plan.
Mammogram Certification Number	Displays the mammogram certification number.
Medical Record #	Displays the medical record number assigned to the member by the provider for the service(s) provided.
Member ID	Displays the Georgia Medicaid identification number of the member who received the service on the claim.
Modifier 1	Displays the primary code used in combination with a procedure code to further define the service provided.
Modifier 2	Displays the secondary code used in combination with a procedure code to further define the service provided.
Modifier 3	Displays the tertiary code used in combination with a procedure code to further define the service provided.
Modifier 4	Displays the fourth code used in combination with a procedure code to further define the service provided.
Modifiers [List]	Displays the code(s) used in combination with a procedure code to further define the service provided.
NDC	Displays the national drug code used to identify a specific drug.
Ordering Provider ID	Displays the NPI or Georgia Medicaid identification number of the ordering provider.
Ordering Provider Name (Last, First, MI)	Displays the last, first name and middle initial of the ordering provider.

Field	Description
Other Insured Identifier	Displays the subscriber's identification number as assigned by the payer.
PA/Precert Number	Displays the prior authorization/precertification number that authorized the rendered service(s). Information entered at the header will indicate the number should be applied against all details where the service requires prior authorization/precertification.
Paid Amount	Displays the dollar paid by Medicare or the other insurance for the service provided.
Paid Date	Displays the date that Medicare or the other insurance paid for the service.
Patient Account Number	Displays the identification number for a member assigned by a provider and used in their system.
Patient Responsibility	Displays the amount the provider feels the patient is responsible for paying.
Payer ID	Displays the carrier code that identifies the insurance plan for the detail.
Payer Identifier	Displays the other payer's Payer ID Number. For Medicare crossovers, enter payer ID#. For other health insurance, enter the Carrier ID# as listed in the TPL carrier listing on the Provider Information > Reports page.
Payer Resp	Displays the payer's level of responsibility for adjudicating the claim.
POS	Displays the place where the service was rendered.
Primary Care Provider ID	Displays the NPI or Georgia Medicaid identification number of the primary care provider, also known as the second referring provider.
Primary Care Provider Name (Last, First, MI)	Displays the last, first name and middle initial of the referring provider.
Procedure	Displays the code used to uniquely identify a procedure.
Procedure Description	Displays the short description of the procedure code, which is automatically populated based on the description on file for the procedure code entered. The value will be displayed as part of the panel, which will automatically adjust the width of the panel to ensure the entire description is displayed. (Read-Only)
RA Date	Displays the date of the remittance advice where this claim was processed per the financial cycle. A zero date indicates

Field	Description
	that the claim has been adjudicated but has not been processed against a remittance advice. (Read-Only)
RA Paid Amount	Displays the amount paid for the service(s). Paid amount does not guarantee payment, as that is determined when the remittance advice is generated.
RA Paid Date	Displays the date of the remittance advice where this claim was processed per the financial cycle. A zero date indicates that the claim has been adjudicated but has not been processed against a remittance advice. Field appears in place of the Denied Date when the header claim status has been paid. (Read-Only)
Referral Number	Displays the referral number issued as a result of a referral from the primary provider.
Referring Provider ID	Displays the NPI or Georgia Medicaid identification number of the referring provider.
Referring Provider Name (Last, First, MI)	Displays the last, first name and middle initial of the referring provider.
Related Causes Code 1	Displays if the accident occurred at work, in an automobile or an environment other than work or an automobile.
Related Causes Code 2	Displays if the accident occurred at work, in an automobile or an environment other than work or an automobile.
Relationship	Displays the relationship of the member to the subscriber of the insurance.
Release of Information	Displays the release of information permission.
Rendering Provider	Displays the Georgia Medicaid identification number of the substitute rendering provider for the service provided.
Rendering Provider ID	Displays the NPI or Georgia Medicaid identification number of the rendering provider, which is automatically captured based on the provider web account used to create the claim. (Read-Only)
Rendering Taxonomy	Displays the Rendering Taxonomy code for the provider.
Report Type	Displays the type of document, report, or supporting item.
re-submit	This button submits modifications made to a denied claim for adjudication.

Field	Description
Sequence	Displays the sequence number that indicates the position that the diagnosis is to appear on the claim such as principal, secondary, tertiary, etc.
Service Facility ID	Displays the NPI or Georgia Medicaid identification number of the service facility.
Status	Displays the status of the claim detail line. (Read-Only)
submit	This button submits a claim for adjudication.
To DOS	Displays the ending date on which service was provided.
top of page	This button jumps the user to the top of the page.
Total Charges	Displays the total amount charged for the claim, which is automatically calculated from the detail charges. (Read-Only)
Total Paid Amount	Displays the total amount paid for the claim. The paid amount does not guarantee payment, as that is determined when the remittance advice is generated. (Read-Only)
Total TPL Amount	Displays the total amount paid by a third party liability plan(s) for the service(s) provided, which is automatically calculated from the Other Payer amounts on the Other Payer panel. (Read-Only)
Transmission	Displays the transmission method by which the attachments are to be sent. The upload capability will be made available when the transmission type is electronic.
Units	Displays the number of units billed for the service.
void	This button submits a void request for a paid claim.

4.13.1 Creating a New Professional Claim

Note: Fields marked with an asterisk are required. Otherwise, the field is optional.\

Step	Action	Result
I. Professional Claim Section		
1	Select Rendering Taxonomy from drop-down list.	
2	Enter the Member ID.*	
3	Enter the Member's Last Name.*	

Step	Action	Result
4	Enter the Member's First Name.* Note: MI (middle initial) is an optional field.	
5	Enter the member's Date of Birth.*	
6	Select the member's Gender.*	
7	Enter the Patient Account #.	
8	Enter the Medical Record #.	
9	Enter the Referring Provider or click [Search] to select from list.	Clicking [Search] activates the Referring Provider Search panel.
10	Select an EPSDT Referral Indicator from the drop-down list.	
11	Select an EPSDT Referral Code1 from the drop-down list.	
12	Select an EPSDT Referral Code2 from the drop-down list.	
13	Select an EPSDT Referral Code3 from the drop-down list.	
14	Select a Release of Information from the drop-down list.*	
15	Select a Related Causes Code 1 accident related cause indicator from the drop-down list.	
16	Select a Related Causes Code 2 accident related cause indicator from the drop-down list.	
17	Select an Accident State from the drop-down list.	
18	Enter the Accident Date.	
19	Enter the Admit Date.	
20	Enter the Discharge Date.	
21	Enter the Date of Death.	
22	Enter the Patient Responsibility.	
23	Enter the PA/Pre-cert Number.	

Step	Action	Result
24	Enter the Referral Number.	
II. Diagnosis Section Must click add to activate the panel before anything can be entered or selected.		
1	Select the Sequence from the drop-down list.*	
2	Enter the Diagnosis or click [Search] to select from list.*	Clicking [Search] activates the Diagnosis Search panel.
III. Other Payer Claims Data Section Optional unless third party liability (TPL) and/or Medicare information need to be indicated against the claim. Must click add to activate the panel before anything can be entered or selected.		
1	Select a Claims Filing from the drop-down list.*	
2	Select a Relationship to Insured from the drop-down list.*	
3	Enter the policy holder Last Name.*	
4	Enter the policy holder First Name.* Note: MI (middle initial) is an optional field.	
5	Select a Payer Resp.*	
6	Enter an Authorization Number.	
7	Enter the Payer Identifier.*	
8	Enter the Insurance Company Name.	
9	Enter the Group Name.	
10	Enter the Group or Policy Number.	
11	Select the Insurance Type Code from the drop-down list.	
12	Enter the Paid Date.	
13	Enter the Paid Amount.	
IV. Other Payer Adjustment Information Section Optional unless third party liability (TPL) and/or Medicare coinsurance, deductibles, and so forth, need to be indicated against the claim. Must click add to activate the panel before anything can be entered or selected.		

Step	Action	Result
1	Select a Claim Adjustment Group Code from the drop-down list.*	
2	Enter the Adjustment Amount.	
3	Enter the Adjustment Reason Code or click [Search] to select from list.*	Clicking [Search] activates the Adjustment Reason Code search panel.
4	Enter the Adjustment Quantity.	
V. Detail Panel Must click add to activate the panel before anything can be entered or selected.		
1	Enter the From DOS.*	
2	Enter the To DOS.	
3	Enter the POS.*	
4	Enter the Procedure or click [Search] to select from list.*	Clicking [Search] activates the Search panel.
5	Enter Modifier 1 or click [Search] to select from list.	Clicking [Search] activates the Search panel.
6	Enter Modifier 2 or click [Search] to select from list.	Clicking [Search] activates the Search panel.
7	Enter Modifier 3 or click [Search] to select from list.	Clicking [Search] activates the Search panel.
8	Enter Modifier 4 or click [Search] to select from down list.	Clicking [Search] activates the Search panel.
9	Select a Diagnosis Code Pointer(s) from the drop-down list, based on the diagnosis sequence association that was entered on the Diagnosis Panel.*	
10	Enter the Units.*	
11	Enter the Charges.*	
12	Enter the Rendering Provider.	
13	Select an Emergency indicator from the drop-down list.	
14	Select an EPSDT Family Planning from the drop-down list.	
15	Enter the PA/Pre-cert Number.	

Step	Action	Result
16	Enter the Mammogram Certification Number.	
17	Enter the DME Serial Number.	
18	Enter the NDC or click [Search] to select from down list.	Clicking [Search] activates the Search panel.
19	Enter the Drug Unit Count.	
20	Select the Drug Unit of Measure from the drop-down list.*	
VI. Detail Other Payer Information Section Optional unless third party liability (TPL) and/or Medicare information need to be indicated against the claim detail. Must click add to activate the panel before anything can be entered or selected.		
1	Select the Payer ID from the drop-down list.* (This relates to the Payer Identifier entered on the Other Payer Claims Data panel.)	
2	Enter the Paid Amount.	
3	Enter the Paid Date.	
VII. Detail Other Payer Adjustment Information Section Optional unless third party liability (TPL) and/or Medicare coinsurance, deductibles, and so forth, need to be indicated against the claim. When the Payer ID selected is Medicare Part B, select the row(s) that appear to enter the appropriate Medicare Coinsurance or Deductible amounts, if applicable. Otherwise, click add to activate the panel before anything can be entered or selected.		
1	Select the Claim Adjustment Group Code from the drop-down list.*	
2	Enter an Adjustment Amount.	
3	Enter an Adjustment Reason Code or click [Search] to select from list.*	Clicking [Search] activates the Adjustment Reason Code search panel.
4	Enter an Adjustment Quantity.	
5	Click add in Detail section to add another service line and repeat steps 48 thru 66 and steps 67 thru 73 (if Medicare or TPL related).	Activates fields for entry of data or selection from lists.

Step	Action	Result
VIII. Hard-Copy Attachments Optional unless attachment information needs to be included against the claim. Must click add to activate the panel before anything can be entered or selected.		
1	Enter the Control Number *	
2	Select the Transmission indicator from the drop-down list.* Note: Submitting a claim with a transmission type of Electronic Upload or File Transfer allows the claim to suspend for needing an attachment if all other edits are bypassed. Once suspended for needing an attachment, the upload button is available on the Hard-Copy Attachments panel to begin attaching the appropriate .jpg, .jpeg, .pdf or .tiff file against the assigned ICN.	
3	Select a Report Type indicator from the drop-down list.*	
4	Click submit.	The professional claim is submitted and an ICN is assigned.

4.13.2 Adjusting a Professional Claim

Step	Action	Result
Start from the secured Claims menu.		
1	Select the Search (Void, Adjust) submenu.	The Claim Search panel displays.
2	Enter the appropriate search criteria.	
3	Click search.	The Search Results panel displays.
4	Select the professional ICN to be adjusted.	The professional claim is displayed in detail.
5	Click in the field(s) to update and perform update.	
6	Click adjust.	A confirmation pop-up window appears.

Step	Action	Result
7	Click OK to confirm the request.	The adjustment is submitted and the new daughter claim ICN and information is displayed. Note: If the adjustment is rejected, a new ICN beginning with "20" will appear with the appropriate denial reasons displayed on the EOB Information panel.

4.13.3 Voiding a Professional Claim

Step	Action	Result
Start from the secured Claims menu.		
1	Select the Search (Void, Adjust) submenu.	The Claim Search panel displays.
2	Enter the appropriate search criteria.	
3	Click search.	The Search Results panel displays.
4	Select the professional ICN to be adjusted.	The professional claim is displayed in detail.
5	Click void and OK to confirm the request.	A confirmation pop-up window appears.
6	Click OK to confirm the request.	The void is submitted and the new daughter claim ICN and information is displayed. Note: If the void request is rejected, a new ICN beginning with "20" will appear with the appropriate denial reasons displayed on the EOB Information panel.

4.13.4 Submitting Attachments Using Web Portal

Attachments can be included as part of the Web submission process. The ability to upload an electronic attachment is provided once the user submits the claim, through the Web Portal, with a transmission type of electronic upload. If the response indicates the claim will be suspended for attachments, the upload ability will be provided for the user to attach their electronic file with the claim. If you are unable to submit attachments using the Web Portal see Appendix C-11, Attachment form for Electronically Submitted Claims.

4.13.5 How to Download the Remittance Advice (RA) from the secure Web Portal

This produces a print image of the paper RA. All providers will have access to a PDF version of their paper Remittance Advice. This is not the X12N 835 transaction. An 835 transaction is available to providers and delegated trading partners.

To access the PDF version of the RA:

1. Log on to the secure Web site.

2. Navigate to the Reports menu option and select the financial reports sub-menu.

3. Complete the Reports search panel and click search to review the available RAs within the time period requested.

4. To begin the download process, click the file name of the desired files to download.

5. To download the report, click Save.

6. The Save As dialog box opens. Save the file to a local directory. The files may be renamed if desired, but it is not necessary to do so.

7. Click Save.

8. When the download process is complete, the download dialog box prompts to Open or Close the file. This is at the user's discretion.

5 Claims Processing

5.1 Introduction

Claims for Medicaid reimbursement are processed by Gainwell Technologies. This chapter describes claims processing and gives the provider information about remittance advice and how to obtain help with claim processing.

5.2 Claims Processing

5.2.1 Claim Entry

Electronic claims are loaded by batch into the GAMMIS.

5.2.2 Claim Adjudication

The GAMMIS analyzes the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

5.3 Remittance Advice (RA)

5.3.1 Description

Medicaid and Medicaid/Medicare crossover claims which are paid, denied, adjusted, or placed in-process by the Division will be listed on the RA. The information contained on the RA is intended to assist the provider in reconciling Medicaid accounts and to assist the Division in guarding against false or erroneous billings. RAs will be provided to providers through the mail or the provider's Message Center on Gainwell Technologies Web Portal at www.mmis.georgia.gov. The electronic RAs are available in a HIPAA-compliant format and a PDF version of the paper RA.

5.3.2 Role of the RA

The RA plays an important role in communications between the provider and Medicaid. It tells what happened to the claims submitted for payment – whether they were paid, denied, in process, or adjusted. It provides a record of transactions and assists the provider in resolving errors so that denied claims can be resubmitted.

The RA must be reconciled to the claim in order to determine if correct payment was received. The date on the first line of each page is the date the financial cycle began, e.g., Friday. The issue date is the date the check was mailed to the provider or an electronic funds transfer (EFT) was sent to the bank for transmission.

The RA contains one or more of the following sections depending on the type of claim filed, the disposition of those claims, and any new billing or policy announcements. Each section starts on a new page:

1. RA Banner Page Message which will be included on every RA
2. Claim Statuses: Paid, Denied, In Process (includes suspended claims), Adjusted
3. Financial Transactions
4. Summary Section which will be included on every RA

5. EOB Reason Code Description

5.3.3 RA Banner Message

When Medicaid or Gainwell Technologies discovers billing problems encountered by all or select provider types, a RA banner message is printed as the first page of the advice. Suggestions for avoiding problems, explanations of policy, and new or changed procedure codes are described. Training sessions are also announced on the RA banner page.

5.3.4 Claim Statuses

Paid Claims: The RA will list each claim paid, the date of service, the amount paid for each service on the claim, and the total amount paid for each claim. Some paid claims may have disallowed lines. These disallowed lines are actually denied charges and may be resubmitted. The reason for the disallowance is listed to the left of the line that was disallowed.

Note: Some claims in paid status may have paid zero dollars.

In Process (includes Suspended claims): This RA will identify claims that require further research, evaluation, or other action by the Division before they can be paid or denied. As long as a claim is suspended, it is not necessary for a provider to submit a duplicate claim. The Pending Claims section will reflect only those claims that have entered the Division's computer system. Claims that have been received by Gainwell Technologies but are still being prepared for computer entry will not be shown. It is the responsibility of the provider to ensure that each and every claim is received by Gainwell Technologies within applicable deadlines for submission and resubmission. If a claim does not appear as pending, or if a claim ceases to appear on the pending report and the provider is not aware of its payment or denial, the provider bears the responsibility for inquiring about the claim's status and taking appropriate action.

Denied Claims: The RA indicates the adjustment reason code(s) and remark code(s) which determine why a particular claim or service could not be paid. The denial of a claim constitutes the termination of the transaction between the Division and the provider for the services billed. Any reconsideration for payment must be initiated by the provider through a new claim. If the provider does not intend to resubmit the claim, the charges for the services should be written off any accounts receivable records maintained by the provider since no further action will be taken by the Division.

Adjustments: The RA will indicate positive adjustments to previous payments made to the provider and negative adjustments resulting from rate changes, retrospective review, or other actions by the provider or the Division.

5.3.5 Financial Transactions

The RA will indicate refund adjustments, recoupments subtracted from the amount payable, voluntary refunds by the provider, and lump sum payouts.

5.3.6 Summary Section

The Summary Section is used to denote the total of all claims for the provider's RA including Claims Data, Earnings Data, and Current Deductions. The total capitation payment is included on the summary page.

5.3.7 EOB Reason Code Description

The Explanation of Benefits (EOB) Reason Code section contains an explanation for all EOB codes and reason codes shown on all previous pages of the RA.

All claims for each provider that are entered in the GAMMIS during the weekly cycle are listed on a RA. Following are examples of each type of CMS-1500 RA and the field descriptions.

```
REPORT:   CRA-BANN-R                                             GEORGIA DEPARTMENT OF COMMUNITY HEALTH                                  DATE: MM/DD/CCYY
RA#:       999999999                                             MEDICAID MANAGEMENT INFORMATION SYSTEM                                  PAGE:       99999
                                                                       PROVIDER REMITTANCE ADVICE
                                                                            BANNER MESSAGES

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                          PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                              NPI ID:              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                                              PAYMENT NUMBER:       999999999
XXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                                                              ISSUE DATE:          MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

   ********************************************************************************************
   ********************************************************************************************

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 4: Illustration Banner Page Message

```
REPORT:   CRA-PHPD-R                          GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:  MM/DD/CCYY
RA#:       999999999                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                    PROVIDER REMITTANCE ADVICE
                                                  CLAIM TYPE M - CMS 1500 PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             NPI ID:              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                             PAYMENT NUMBER:       999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                              ISSUE DATE:          MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------------------------------
ICN             MEMBER ID     MEMBER NAME                 BILLED DTE   P AUTH NO        PATIENT NUMBER
COS     FROM DTE - THRU DTE            BILLED           ALLOWED      COPAY/DEDUCT           PT LIAB               COB        TOTAL PAID
-------------------------------------------------------------------------------------------------------------------------------------------------------
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX   MMDDYYYY     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXX     MMDDYYYY   MMDDYYYY      9,999,999.99      9,999,999.99        999,999.99        999,999.99      9,999,999.99      9,999,999.99          PAID
  HEADER EOBS:  9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

LNN FROM DTE-THRU DTE  POS SPEC  PROC CD M1 M2 M3 M4 UNIT/MILE        BILLED       ALLOWED          COB          PAID  DETAIL EOBS             STATUS
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   PAID
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   DENY
      DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DTE: MMDDYY                                                      9999 9999 9,999,999.99-
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   PAID
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
 (The following detail is an example of procedure J-code, where the 11 character NDC code appears in the Modifiers section.)
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XXXXXXXXXXX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   PAID
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

TOTAL CMS 1500 CLAIMS PAID:  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99
```

Figure 5: Sample CMS-1500 Claims Paid

```
REPORT:   CRA-PHDN-R                          GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:  MM/DD/CCYY
RA#:       999999999                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                    PROVIDER REMITTANCE ADVICE
                                                CLAIM TYPE M - CMS 1500 DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          NPI ID:              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          PAYMENT NUMBER:       999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                         ISSUE DATE:          MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------------------------------
ICN             MEMBER ID     MEMBER NAME                 BILLED DTE   P AUTH NO        PATIENT NUMBER
COS       FROM DTE - THRU DTE            BILLED           ALLOWED      COPAY/DEDUCT           PT LIAB               COB        TOTAL PAID
-------------------------------------------------------------------------------------------------------------------------------------------------------
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX   MMDDYYYY     XXXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXX       MMDDYYYY   MMDDYYYY      9,999,999.99      9,999,999.99        999,999.99        999,999.99      9,999,999.99      9,999,999.99         DENY
  HEADER EOBS:  9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

LNN FROM DTE-THRU DTE  POS SPEC  PROC CD M1 M2 M3 M4 UNIT/MILE        BILLED       ALLOWED          COB          PAID  DETAIL EOBS             STATUS
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   DENY
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   DENY
      DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DTE: MMDDYY                                                        9999 9999 9,999,999.99-
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   DENY
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
 (The following detail is an example of procedure J-code, where the 11 character NDC code appears in the Modifiers section.)
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XXXXXXXXXXX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   DENY
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

TOTAL CMS 1500 CLAIMS DENIED:  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99
```

Figure 6: Sample CMS-1500 Claims Denied

```
REPORT:   CRA-PH3U-R                          GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:  MM/DD/CCYY
RA#:       999999999                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                      PROVIDER REMITTANCE ADVICE
                                                  CLAIM TYPE M - CMS 1500 IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           NPI ID:              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           PAYMENT NUMBER:       999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                          ISSUE DATE:          MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------------------------------------
ICN             MEMBER ID     MEMBER NAME                  BILLED DTE   P AUTH NO        PATIENT NUMBER
COS          FROM DTE - THRU DTE              BILLED           ALLOWED      COPAY/DEDUCT           PT LIAB               COB        TOTAL PAID
-------------------------------------------------------------------------------------------------------------------------------------------------------
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXX   MMDDYYYY     XXXXXXXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXX          MDDYYYY   MMDDYYYY         9,999,999.99      9,999,999.99        999,999.99        999,999.99      9,999,999.99      9,999,999.99     SUSP
  HEADER EOBS:  9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

LNN FROM DTE-THRU DTE  POS SPEC  PROC CD M1 M2 M3 M4 UNIT/MILE        BILLED       ALLOWED          COB          PAID  DETAIL EOBS             STATUS
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   SUSP
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XX XX XX XX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   SUSP
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
 (The following detail is an example of procedure J-code, where the 11 character NDC code appears in the Modifiers section.)
999 MMDDYYYY MMDDYYYY  XX  XXX   XXXXXX  XXXXXXXXXXX   9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   SUSP
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                      9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

TOTAL CMS 1500 CLAIMS IN PROCESS:  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99  9,999,999,999.99
```

Figure 7: Sample CMS-1500 Claims in Process

```
REPORT:   CRA-TRAN-R                          GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:  MM/DD/CCYY
RA#:       999999999                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                    PROVIDER REMITTANCE ADVICE
                                                      FINANCIAL TRANSACTIONS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           NPI ID:              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           PAYMENT NUMBER:       999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                           ISSUE DATE:          MM/DD/CCYY


   ---------------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS---------------

   TXN NUMBER     CCN           PAYOUT AMOUNT    RSN CODE
   99999999999    YYJJJBBBSSS    9,999,999.99    9999

   TOTAL PAYOUTS:   99,999,999.99

   ---------------NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS---------------

   CCN            REFUND AMOUNT    RSN CODE
   YYJJJBBBSSS     9,999,999.99    9999

   TOTAL REFUNDS: 99,999,999.99

   -----------------------------ACCOUNTS RECEIVABLE-----------------------

   AR NUMBER        SETUP DTE    RECOUPED THIS CYCLE        ORIGINAL    TOTAL RECOUPED         BALANCE    RSN CODE
   XXXXXXXXXXXXX     MMDDYYYY          9,999,999.99    9,999,999.99      9,999,999.99    9,999,999.99    9999

   TOTAL BALANCE                                                                            99,999,999.99
```

Figure 8: Sample RA Financial Transaction

```
REPORT:   CRA-SUMM-R                          GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:  MM/DD/CCYY
RA#:       999999999                          MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                    PROVIDER REMITTANCE ADVICE
                                                     REMITTANCE ADVICE SUMMARY


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          NPI ID:              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          CHECK/EFT NUMBER:     999999999
XXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                          ISSUE DATE:          MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                          -------------------------CLAIMS DATA---------------------------

                                             CURRENT            CURRENT
                                              NUMBER             AMOUNT
          CLAIMS PAID                      999,999,999   9,999,999,999.99
          CLAIM ADJUSTMENTS POSITIVE       999,999,999   9,999,999,999.99
          CLAIM ADJUSTMENTS NEGATIVE      (999,999,999) (9,999,999,999.99)
             TOTAL CLAIMS PAYMENTS         999,999,999   9,999,999,999.99
          CLAIMS DENIED                    999,999,999
          CLAIMS IN PROCESS                999,999,999

                                          -------------------------EARNINGS DATA-------------------------
          PAYMENTS:
             CLAIMS PAYMENTS                              9,999,999,999.99

             CAPITATION PAYMENT†                          9,999,999,999.99
             SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)          9,999,999,999.99
             ACCOUNTS RECEIVABLE (OFFSETS):              (9,999,999,999.99)
:            ACCOUNTS RECEIVABLE (CLAIM SPECIFIC):       (9,999,999,999.99)

             NET PAYMENT**                                9,999,999,999.99

          REFUNDS:
             CLAIM SPECIFIC ADJUSTMENT REFUNDS           (9,999,999,999.99)
             NON CLAIM SPECIFIC REFUNDS                  (9,999,999,999.99)

          OTHER FINANCIAL:
             VOIDS                                       (9,999,999,999.99)

          NET EARNINGS                                    9,999,999,999.99

                                -----CURRENT DEDUCTIONS------
                          LIEN HOLDER NAME/TYPE                          DEDUCTION AMOUNT
                          xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx       9,999,999,999.99

**  NET PAYMENT AMOUNT HAS BEEN REDUCED.  LIEN PAYMENTS HAVE BEEN MADE TO THE FOLLOWING LIEN HOLDERS.

† CAPITATION PAYMENT FOR THE MONTH OF MM/YY.  PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR ADDITIONAL DETAIL.
```

Figure 9: Sample RA Summary

5.4 How to Read the Remittance Advice (RA)

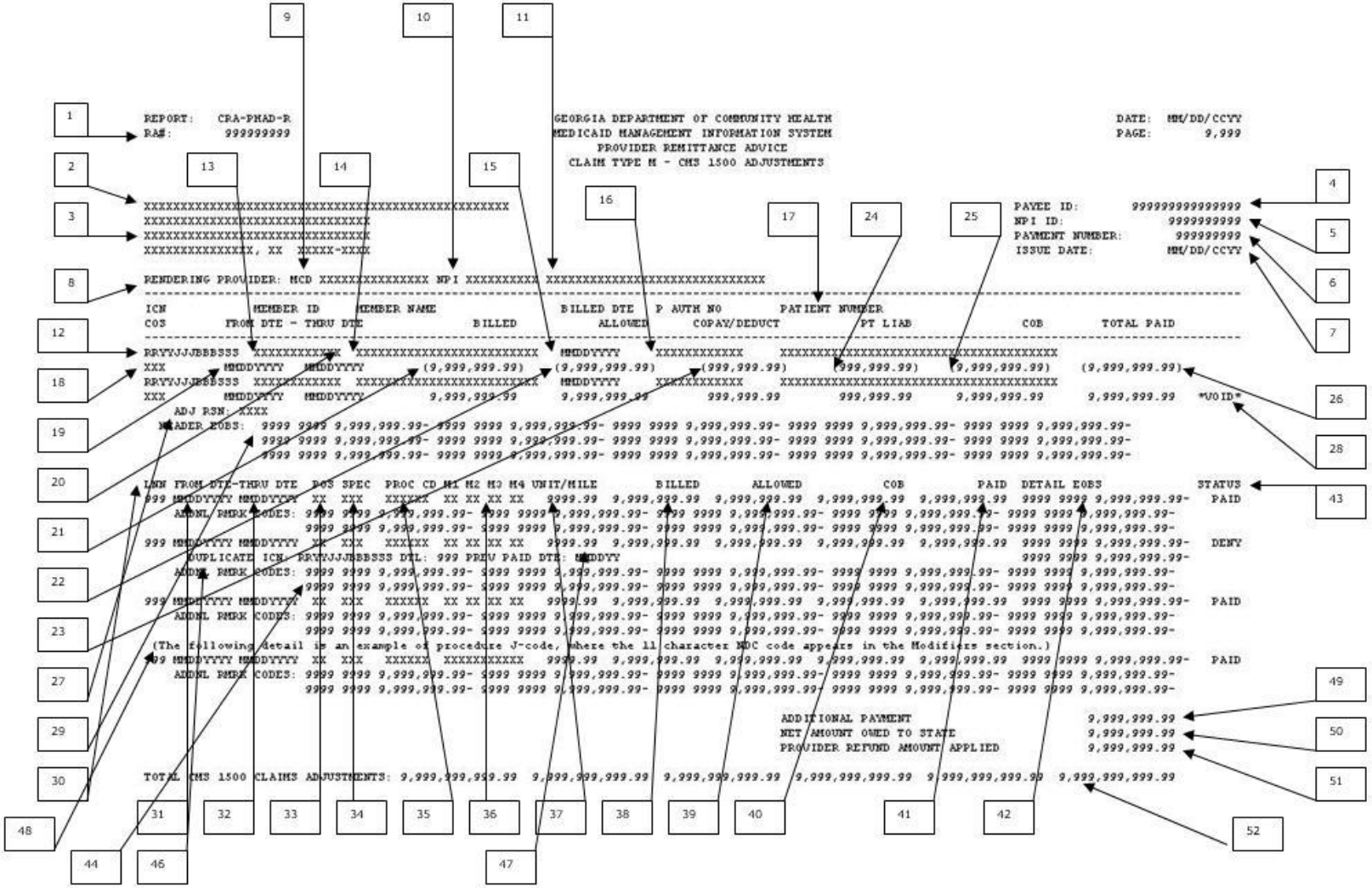


Figure 10: Sample CMS-1500 Claim Adjustments

Field Title ID	Field Title	Field Title Description
1	RA #	RA Number is a unique identifier assigned to the remittance advice.
2	Payee Name	The Name of the Payee displayed above the Address.
3	Address	The 'Pay To' mailing address of the Payee. Displayed in the upper left corner of the RA.
4	Payee ID	This is the unique identifier for the billing entity receiving payment or remittance activity.
5	NPI ID	This is the National Provider ID number that is associated with the provider on the RA.
6	Payment Number	If a check was generated, this is the check number corresponding to the check that was generated. If the provider is an EFT participant, this is the control number of the EFT transaction.
7	Issue Date	This is the date the payment was issued.
8	Rendering Provider	The identifier of the provider that performed the service (i.e. prescribed the drug, performed the dentistry, etc.).
9	Rendering Provider MCD	The Medicaid ID of the rendering provider.
10	Rendering Provider NPI	The NPI ID of the rendering provider.
11	Rendering Provider Name	The name of the rendering provider.
12	ICN	Internal Control Number (ICN) is a unique number used to identify and track a claim processed through the system. Format is RRYYJJJBBBSSS where RR is region, YY is year, JJJ is Julian day, BBB is batch, and SSS is claim sequence.
13	Member ID	The unique Medicaid identifier of the beneficiary (member).
14	Member Name	The name of the beneficiary (member) identified on the claim.
15	Billed Dte	Date on which the provider or billing service prepared the claim form to be submitted.

Field Title ID	Field Title	Field Title Description
16	P Auth No	This is the number assigned by the PA unit to a Prior Authorization request.
17	Patient Number	The Patient Control Number is a unique number assigned by the provider. This is usually used for filing or tracking purposes.
18	COS	Code for the State category of service (COS) that defines the grouping of services appearing on State MAR reports.
19	From Dte (Header)	This is the earliest date of service or admission date for the claim.
20	Thru Dte (Header)	This is the latest date of service or discharge date for the claim.
21	Billed (header)	This is the dollar amount requested by the provider for the claim. The Header Billed Amount is arrived at by adding the Detail Billed Amounts on all the detail lines.
22	Allowed (header)	This is the computed dollar amount allowable for the claim. The header amount is arrived at by pricing each of the individual details and adding up the individual prices.
23	Copay/Deduct	The dollar amount of member responsibility on a claim that is to be collected by the provider at the time the service is rendered. Copay is used interchangeably with coinsurance. The Header Copay Amount is arrived at by adding the Detail Copay Amounts on all the detail lines.
24	Pt Liab	Amount member is responsible to pay for services rendered.
25	COB (Header)	TPL Amount is the dollar amount paid by sources other than the state Medical Assistance Program being billed. If present, this amount is subtracted from the allowed amount.
26	Total Paid	This is the dollar amount that is payable for the claim.
27	Adj Rsn	Adjustment Reason is the EOB code entered when the claim was adjusted, indicating the reason for initiating the claim adjustment.

Field Title ID	Field Title	Field Title Description
28	Voided Claim Indicator	This field contains VOID when the adjustment claim voids the original claim.
29	Header EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim or adjustment header. These codes are used to explain how the claim or adjustment was processed or priced. There could be a maximum of 20 EOB codes. For each "EOB", the RA will display the System EOB Code the corresponding HIPAA Adjustment Reason Code and the cutback amount. Each "EOB" will be variable in length, from 4 to 23.
30	LNN	The number of the detail on a claim record.
31	From Dte (Detail)	This is the earliest date of service or admission date for the claim detail.
32	Thru Dte (Detail)	This is the latest date of service or discharge date for the claim detail.
33	POS	This is the place of service.
34	Spec	Code which indicates the scope of practice or operations of the billing provider.
35	Proc Cd	This is the code used to indicate what services were actually rendered to the member by the provider.
36	M1 M2 M3 M4	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.
37	Unit/Mile	Quantity dispensed for the drug expressed in metric decimal units.
38	Billed (Detail)	This is the dollar amount requested by the provider for the item billed on each detail line.
39	Allowed (Detail)	This is the computed dollar amount allowable for the detail item billed.
40	COB (Detail)	TPL Amount is the dollar amount paid by sources other than the state Medical Assistance Program being billed. If present, this amount is subtracted from the allowed amount.

Field Title ID	Field Title	Field Title Description
41	Paid	This is the dollar amount that is payable for the claim.
42	Detail EOBS	These are the Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. For each "EOB", the RA will display the System EOB Code the corresponding HIPAA Adjustment Reason Code and the cutback amount. Each "EOB" will be variable in length, from 4 to 23.
43	Status	The claim line item status: PAID, DENY, SUSP.
44	Addnl Rmrk Codes	This is a continuation of the Detail EOBs in the event that they do not all fit in the Detail EOB space.
45	Duplicate DTL	The number of the detail line that was a duplicate of the detail shown. This field is only shown when the claim detail was denied because there was a duplicate claim detail.
46	Duplicate ICN	The ICN of the claim that was a duplicate of the claim shown. This field is only shown when the claim header or detail was denied because there was a duplicate claim header or detail.
47	Prev Paid Dte	The previous paid date of the claim that was a duplicate of the claim shown. This field is only shown when the claim was denied because there was a duplicate claim.
48	NDC Code	When there is a J-code Procedure Code then the NDC will be displayed under the Modifiers section of the claim detail. The National Drug Code is comprised of a five-byte numeric labeler code, four-byte numeric product code, and a two-byte numeric package code. Used to uniquely identify a drug, its labeler & package size of a product for pricing and service/prior authorization.
49	Additional Payment	This is an additional payment.
50	Net Amount Owed To State	This is the additional amount owed by a billing provider as the result of a claim adjustment. If this amount cannot be recovered in the current

Field Title ID	Field Title	Field Title Description
		cycle, an accounts receivable record is generated.
51	Provider Refund Amount Applied	The Refund Amount Applied is the amount of a cash receipt received from the provider applied to a cash related claim adjustment.
52	Total CMS-1500 Claim Adjustments	This is the grand total dollar amounts for this section of the remittance report.

5.5 How to Resubmit a Denied Claim

Check the RA before submitting a second request for payment.

Claims may be resubmitted for one of the following reasons only:

- The claim has not appeared on a RA as paid, denied, or suspended for 30 days after it was submitted.
- The claim was denied due to incorrect or missing information or lack of a required attachment.

Do not resubmit a claim denied because of Medicaid program limitations or policy regulations. Computer edits ensure that it will be denied again.

Resubmitted claims must be original claims, not copies.

If the claim does not appear on a RA within 30 days of the day the provider mailed it, the following steps should be taken**:**

- Check recently received RA dates. Look for gaps. A RA may have been mailed but lost in transit. If the provider believes this is the case, call Gainwell Technologies, Provider Service Contact Center at 1-800-766-4456.
- If there is not a gap in the dates of RA received, please call Gainwell Technologies Provider Services Contact Center at 1-800-766-4456. A representative will research the claim.
- If Gainwell Technologies advises that the claim was never received, please resubmit another claim immediately. See the Resubmission Checklist on the following page.

If the claim has denied for incorrect or missing information, correct the errors prior to resubmitting the claim.

5.5.1 Resubmission Checklist

Use the following checklist to ensure that resubmittals are completed correctly before submitting.

- Did you wait 30 days after the original submittal before resubmitting a missing claim?
- When completing a new claim, did you type or print the form in black ink? Are all multi-part copies legible?
- If you have corrected or changed the original claim form, have strikeovers been corrected on each copy? Do not use whiteout.
- Has the resubmitted claim been signed again and dated?
- Have you included all required attachments and documentation with the claim form?

- Is the claim clean of all highlighting and whiteout?
- Do you have the correct P.O. Box number and corresponding nine-digit ZIP code for mailing the resubmitted claim? Resubmitted claims should be sent to the same P.O. Box as the original claim.

Do you have any questions about resubmitted claims that are not answered in this manual? If so, please contact Gainwell Technologies, Provider Contact Services Center at 1-800-766-4456.

5.6 When to Submit an Adjustment and Void

The adjustment and void process allows any adjudicated individual or multiple claims to be adjusted or reprocessed due to a rate change or a claim data error. Paid claims are adjusted and denied claims are reprocessed. Adjustments may be submitted by DCH, by the provider, or can be system generated resulting in an adjudicated claim with updated data. The end result for a void is a denied claim. Refer to section 205 in the Part I Policy and Procedures Manual for more information.

5.6.1 Adjusting an Incorrect Payment

A provider who receives an incorrect payment for a claim or receives payment from a third party after Medicaid has made payment is required to submit an adjustment or a void to correct the payment. Refer to section 205 in the Part I Policy and Procedures Manual.

5.6.2 Adjustment

An adjustment is needed if the correction to the payment would result in a partial refund or the claim was underpaid. Only paid claims can be adjusted. Adjustment requests must be received within three months following the month of the Medicaid payment. The payment date is reflected in the date located in the top right hand corner of the RA page. When an adjustment is performed, the original claim is voided resulting in the recovery of the entire paid amount. A new claim, the adjustment claim, is then created in the system, which incorporates the necessary requested changes and repays the provider for the services rendered. A paid claim can only be adjusted once due to this void and recovery process; however, an adjustment can be requested to the adjustment claim if additional changes are needed.

5.6.3 Void

A void is needed if the correction to the payment would result in a complete refund of the Medicaid payment to Gainwell Technologies **for the following reasons:**

- A provider was overpaid for a claim.
- A provider was not reimbursed for the correct amount.
- The individual receiving treatment, listed on the RA, is not a patient of the provider who received the RA.
- A payment was received by the wrong provider, and the payment is returned.
- A claim was paid to the provider twice.

- A check was paid to a provider who does not belong to the group or has left the group.

- The payment was inappropriately made payable to the wrong location or provider identification number.

5.7 Financial Summary Page Adjustment

5.7.1 Adjusting a Paid Claim

You must submit an Adjustment Request form or adjust the claim using the Web Portal to correct the claim payment when:

- An inaccurate claim payment is received.

- A payment was received from a third party after Medicaid has paid.

5.7.2 Refund Adjustments Due to Error

You should use a personal/company check to refund a Medicaid overpayment. If the overpayment is due to an error on the claim, then you can include a completed Adjustment Request form with the overpayment refund. The completed form should include, within the narrative, the correct data to be applied to the claim.

5.7.3 Refund Adjustments Due to Third-Party Overpayment

You must refund payments that were received from a third party after Medicaid had already paid the claim. Adjustments can also be done on the Web, creating a receivable against future payments. A refund is due within 30 days after the provider received the overpayment. Along with the refund check, the provider should also send these three items:

- A completed Adjustment Request form

- A copy of the Medicaid RA that corresponds to the claim payment

- A copy of the RA received from the third party

All refund checks and accompanying documentation must be mailed to the following address. Providers and hospitals use separate addresses.

Provider

Bank of America

Lock Box 277941

Atlanta, GA 30384

5.7.4 Filing Limitation

Adjustment requests must be received within three months following the month of Medicaid payment. The payment date is reflected in the date located in the top right hand corner of the RA page. Only paid claims can be adjusted. When an adjustment is performed, the original claim is voided resulting in the recovery of the entire paid

amount. A new claim, the adjustment claim, is then created in the system, which incorporates the necessary requested changes and repays the provider for the services rendered. A paid claim can only be adjusted once due to this void and recovery process; however, an adjustment can be requested to the adjustment claim if additional changes are needed. Refer to the Adjustment Request form (DMA-501) in section 5.9 for instructions on how to complete it.

5.7.5 Adjustment of Inaccurate Medicare/Medicaid Payments

To appeal the amount paid for services for Medicaid/Medicare members, notify the appropriate Medicare Fiscal Intermediary of your appeal. Any additional payment is through both Medicare and Medicaid. If the payments are made to an incorrect provider or are above the amount due, return the erroneous checks or issue refunds to Medicare and to Medicaid for their respective shares. Any erroneous Medicaid payments or refunds due to DCH must be forwarded to the following address:

Provider

Bank of America

Lock Box 277941

Atlanta, GA 30384

Adjustment Request Form

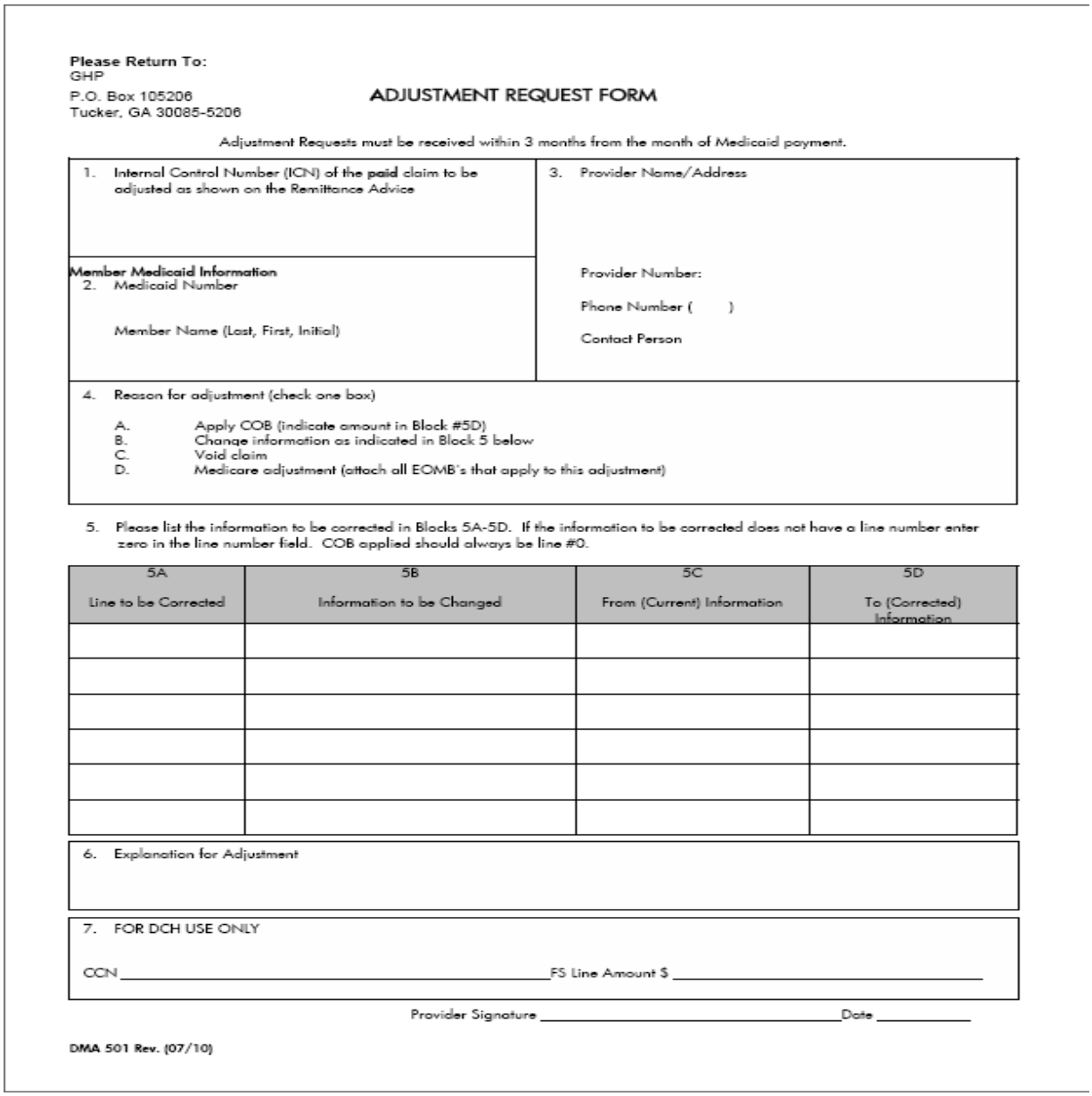
Gainwell Technologies

P.O. Box 105206

Tucker, GA 30085-5206

5.8 Adjustment Request Form (DMA-501)

Complete the Adjustment Request Form (DMA-501) as completely and accurately as possible. Incomplete or inaccurate information can delay the adjustment process.



Please Return To:
GHP
P.O. Box 105206
Tucker, GA 30085-5206

ADJUSTMENT REQUEST FORM

Adjustment Requests must be received within 3 months from the month of Medicaid payment.

1. Internal Control Number (ICN) of the **paid** claim to be adjusted as shown on the Remittance Advice

3. Provider Name/Address

Member Medicaid Information
2. Medicaid Number

Member Name (Last, First, Initial)

Provider Number:

Phone Number ( )

Contact Person

4. Reason for adjustment (check one box)

A. Apply COB (indicate amount in Block #5D)
B. Change information as indicated in Block 5 below
C. Void claim
D. Medicare adjustment (attach all EOMB's that apply to this adjustment)

5. Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number enter zero in the line number field. COB applied should always be line #0.

5A Line to be Corrected	5B Information to be Changed	5C From (Current) Information	5D To (Corrected) Information

6. Explanation for Adjustment

7. FOR DCH USE ONLY

CCN _____ FS Line Amount $ _____

Provider Signature _____ Date _____

DMA 501 Rev. (07/10)

Figure 11: Adjustment Request Form (DMA-501)

5.8.1 Completion of the Adjustment Request Form

Field	Description	Guidelines
1	Transaction Control Number (TCN) / Internal Control Number (ICN)	Enter the 13-digit ICN or the 17-digit TCN assigned to the claim.
2	Member Medicaid Number	Enter the member number exactly as it appears on the RA for the TCN or ICN.
	Member Name	Enter the name of the member exactly as it appears on the RA for the TCN or ICN.
3	Provider Name / Address	Enter the provider's name and address.
	Provider Number	Enter the identifying number assigned by the Provider Enrollment Unit.
	Phone Number	Enter the telephone number, including area code.
	Provider Contact Person	Enter the name of a person who can be contacted regarding the adjustment, if necessary.
4	Reason for Adjustment	Mark an 'X' in the box that best explains the adjustment.
5	Please list the information to be corrected in fields 5A-5D. If the information to be corrected does not have a line number, enter zero in the line number field. COB applied should always be line #0.	Complete 5A-5D as needed.
5A	Line to be Corrected	Enter the line from the RA in field 5A.
5B	Information to be Changed	Write the item to be changed in field 5B, such as procedure code, quantity.
5C	From (Current) Information	Enter the incorrect information in field 5C as it appears on the RA, such as procedure, quantity.
5D	To (Corrected) Information	Write the corrected information for that item in field 5D.

Field	Description	Guidelines
6	Explanation for Adjustment	Use this area to list any additional information that may be needed to process the adjustment request. Always attach a copy of the RA page showing the paid claim information to clarify your request.
7	For DCH Use Only CCN FS Line Amount$	Leave blank.
	Provider Signature and Date	The provider must sign and enter the date.

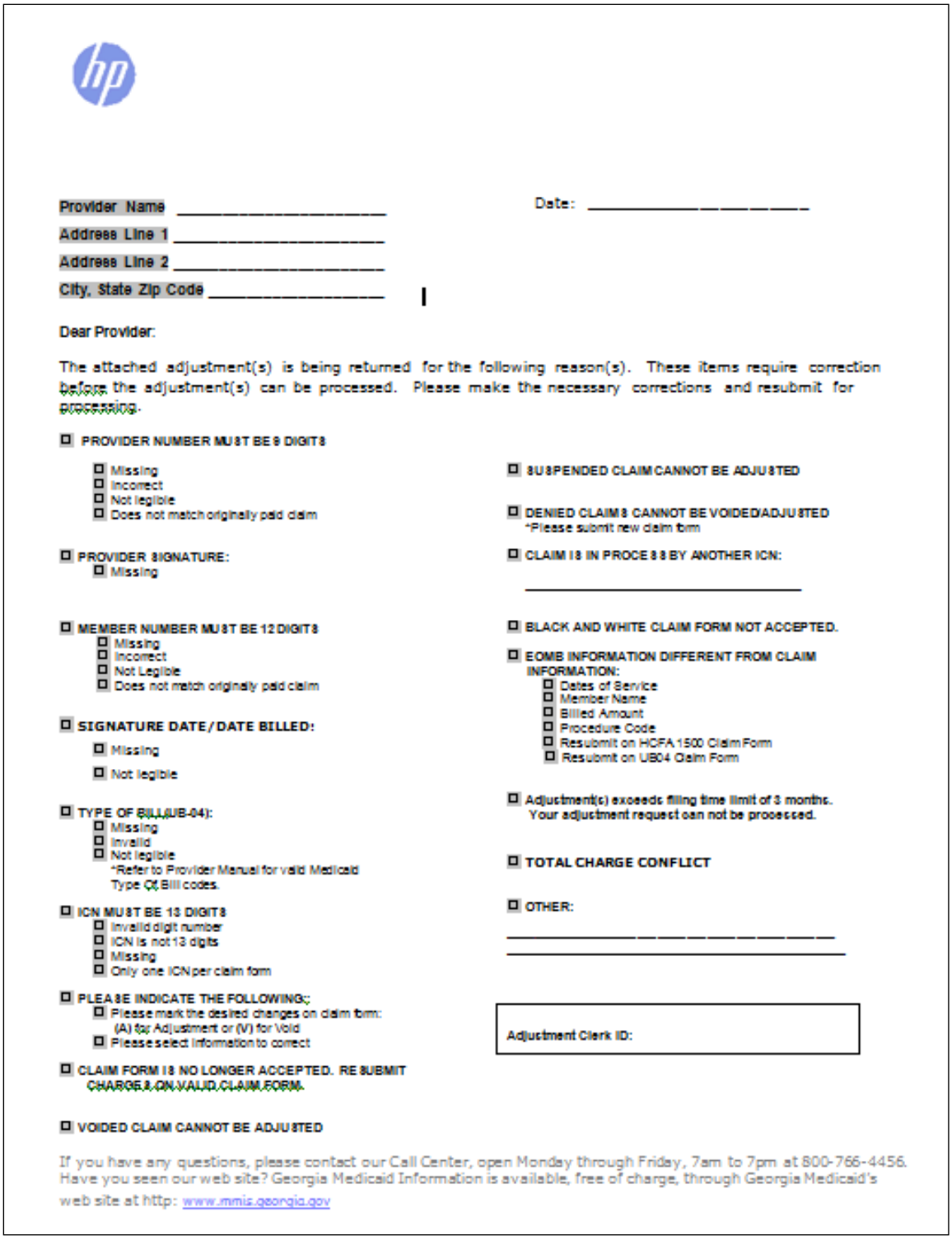
5.9 Return to Provider Adjustment Letter

Examples of missing information required for processing adjustment/voids include:

- Missing signatures
- Print or ink too light to microfilm
- Incorrect/incomplete attachments
- Incorrect claim type
- Provider number incomplete or missing

The adjustment/voids are returned when possible. To process for payment, the adjustment/voids must be resubmitted with the corrected or additional information. Adjustment Return to Provider (RTP) letter attached to the adjustment/voids lists the reason for the returned information.

An example of the Adjustment Return to Provider Letter (see figure 20) is shown on the following page.



Provider Name _____ Date: _____

Address Line 1 _____

Address Line 2 _____

City, State Zip Code _____

Dear Provider:

The attached adjustment(s) is being returned for the following reason(s). These items require correction before the adjustment(s) can be processed. Please make the necessary corrections and resubmit for processing.

☐ PROVIDER NUMBER MUST BE 9 DIGITS
- ☐ Missing
- ☐ Incorrect
- ☐ Not legible
- ☐ Does not match originally paid claim

☐ PROVIDER SIGNATURE:
- ☐ Missing

☐ MEMBER NUMBER MUST BE 12 DIGITS
- ☐ Missing
- ☐ Incorrect
- ☐ Not Legible
- ☐ Does not match originally paid claim

☐ SIGNATURE DATE/DATE BILLED:
- ☐ Missing
- ☐ Not legible

☐ TYPE OF BILL (UB-04):
- ☐ Missing
- ☐ Invalid
- ☐ Not legible

*Refer to Provider Manual for valid Medicaid Type Of Bill codes.

☐ ICN MUST BE 13 DIGITS
- ☐ Invalid digit number
- ☐ ICN is not 13 digits
- ☐ Missing
- ☐ Only one ICN per claim form

☐ PLEASE INDICATE THE FOLLOWING:
- ☐ Please mark the desired changes on claim form: (A) for Adjustment or (V) for Void
- ☐ Please select information to correct

☐ CLAIM FORM IS NO LONGER ACCEPTED. RESUBMIT CHARGES ON VALID CLAIM FORM.

☐ VOIDED CLAIM CANNOT BE ADJUSTED

☐ SUSPENDED CLAIM CANNOT BE ADJUSTED

☐ DENIED CLAIMS CANNOT BE VOIDED/ADJUSTED
*Please submit new claim form

☐ CLAIM IS IN PROCESS BY ANOTHER ICN:
_____

☐ BLACK AND WHITE CLAIM FORM NOT ACCEPTED.

☐ EOMB INFORMATION DIFFERENT FROM CLAIM INFORMATION:
- ☐ Dates of Service
- ☐ Member Name
- ☐ Billed Amount
- ☐ Procedure Code
- ☐ Resubmit on HCFA 1500 Claim Form
- ☐ Resubmit on UB04 Claim Form

☐ Adjustment(s) exceeds filing time limit of 3 months. Your adjustment request can not be processed.

☐ TOTAL CHARGE CONFLICT

☐ OTHER:
_____
_____

Adjustment Clerk ID:

If you have any questions, please contact our Call Center, open Monday through Friday, 7am to 7pm at 800-766-4456. Have you seen our web site? Georgia Medicaid Information is available, free of charge, through Georgia Medicaid's web site at http: www.mmis.georgia.gov

Figure 12: Adjustment Return to Provider Letter

6 Provider Services Contact Center

6.1 Introduction

The Provider Services Contact Center is a key source of support for Georgia Medicaid related matters. The Provider Services Contact Center team of inquiry specialists serves as an important resource for billing information. Providers interact with the Provider Services Contact Center by telephone.

Gainwell Technologies' Provider Services Contact Center is staffed Monday to Friday, between the hours of 7:00 a.m. and 7:00 p.m., Eastern Standard Time. Gainwell Technologies maintains both English and Spanish speaking specialists.

The Provider Services Contact Center is dedicated to responding professionally and accurately to provider inquiries. Provider contact and support is typically related to one of the following areas:

1. Billing procedures
2. Claims disposition
3. Reimbursement
4. Member's eligibility
5. Prior Authorization (PA) status

All Provider Services Contact Center specialists and provider contacts are tracked and recorded for quality purposes.

6.2 Provider Interactive Voice Response System (IVRS) Basic

The Georgia Provider and Member IVRS provide automated access to common inquiries that may be answered over the telephone. This system acts as a first line of support to providers and members by supplying participant information. When callers need further assistance, they can access the Provider Services Contact Center. The IVRS also provides automated access to the Nurse Aide Registry and supports providers and nurse aides in obtaining forms and training program information.

The IVRS is equipped to allow providers to perform multiple requests such as:

1. Member eligibility
2. Claim status
3. Payment information
4. Service limits
5. Prior authorization status
6. Speak to a Provider Services Contact Specialist

Providers can reach a Provider Services Contact Specialist through the following phone numbers:

1. Toll-free IVRS phone number: 1-800-766-4456

2. Local IVRS phone number: 770-325-9600

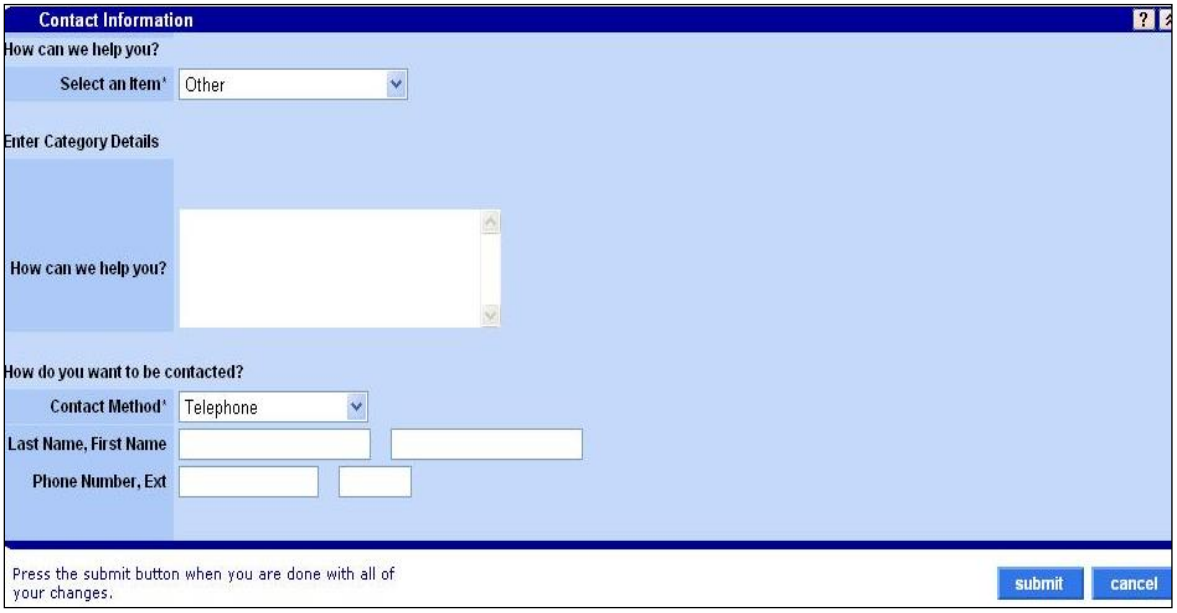
3. Providers not enrolled in the Georgia Medicaid Program can contact other departments within Gainwell Technologies IVRS without a provider number:

    a. Provider Enrollment

    b. EDI

6.3 The Contact Us Function on the Web Portal

The Web Portal is equipped with a public contact page that allows any user to contact Georgia Medicaid regarding a complaint, request, suggestion, etc. The Contact Information panel is located on our website at www.mmis.georgia.gov. Users will navigate to the Contact Information menu and select Contact Us from the available submenu.



Appendix A Resource Tools

This appendix describes how to use the following resource tools:

- Telephone Inquiry
- Medicaid Eligibility Inquiry
- Billing Assistance
- Enrollment Changes
- Return To Provider Letter

A.1 Telephone Inquiry

You can speak with a live Provider Services Contact Specialist, Monday through Friday, 7:00 a.m. to 7:00 p.m. Eastern Standard Time (except holidays). Following are the telephone numbers you can use to contact us:

770-325-9600 (metro Atlanta)

1-800-766-4456 (toll free)

The Provider Contact Services Center will respond to inquiries regarding:

- Billing procedures
- Claims payment/status
- Electronic claim submission
- Program benefits
- Service limitations
- Web Portal functionality

A.2 Medicaid Eligibility Inquiry

Be prepared to provide the information listed below so the Provider Services Contact Specialist can best assist you with your inquiry:

- The 13-digit ICN found on each claim from your RA.
- Provider Number
- Transaction Control Number (TCN)
- Date(s) of Service
- Claim Status (Paid, Denied, In Process, Suspended)
- Member Name and Medicaid number

- The Explanation of Benefit (EOB) or error message, if applicable to your claim.

A.3 Billing Assistance

The policy and billing manuals are always the first point of reference for questions. The billing manual reviews:

- Required claim forms and necessary information
- Sample RAs with explanations
- Billing protocol
- Order information for forms

Billing training and EDI assistance is available to:

- Assist you with billing problems
- Install PES software for electronic billing
- Review billing with your team
- Call the telephone inquiry line to request billing training or assistance.

A.4 Provider Enrollment Changes

As a condition of continued Medicaid provider participation, all notifications of changes in address or enrollment must be made in writing. Enrollment changes that might affect claim reimbursement and that should be reported in writing include:

- Address/location
- Name of institution or business
- Telephone number
- License information
- Medicare provider numbers
- Federal employer identification numbers
- Social security number
- Payee identifying information
- Ownership information

All checks for claim reimbursements that have been determined to be undeliverable by the post office are returned to the Financial Operations team at Gainwell Technologies. Financial Operations personnel attempt to contact the provider by telephone to determine why the check was returned. If the check was returned due

to an unreported address change, the provider is requested to forward a notification of change of address in writing to the Gainwell Technologies Provider Enrollment team. Upon receipt of the updated information, the check is mailed to the new address by the Financial Operations team. The reimbursement check is held in the Gainwell Technologies Financial Operations team until the change information has been received, if the days held exceed 90 to 180 days then the check will be voided.

Appendix B NPI Requirements

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health and Human Services to meet the HIPAA health care provider identification mandate. It is a 10-digit number assigned to health care providers. Once a provider has an NPI, it will not change regardless of job or location changes. It replaces all existing health care provider identifiers including numbers assigned by Medicare, Medicaid, Blue Cross, etc. on standard HIPAA transactions. It will be the number used to identify providers nationally.

B.1 Who needs an NPI?

All Medicaid providers, both individuals and organizations, who are eligible to receive an NPI, are required to have an NPI. This includes:

- All Medicaid healthcare providers
- All CMO healthcare providers.

B.2 The NPI will be required on electronic claims.

Medicaid providers who are not eligible to receive an NPI will maintain their current Medicaid Provider ID.

B.3 When do I need to use my (National Provider Identifier) NPI with Georgia Medicaid?

- Applying to be a Medicaid Provider
- On all electronic claims submission including claims submitted using PES.
- Submitting any X12N (HIPAA) transaction that requires NPI

B.4 When do I need to use my Medicaid Provider Number?

You will need to use your Medicaid Provider Number in the following circumstances:

- Submission of Web claims

IVRS inquiries

- Provider authentication
- All claim inquiries
- All other inquiries

Telephone inquiries

- Provider authentication
- All claim inquiries

- All other inquiries

Prior authorizations

- Requests
- Inquiries

Referrals

- Request
- Inquiries

Medicaid forms

B.5 When do I need both my NPI and my Medicaid Provider Number?

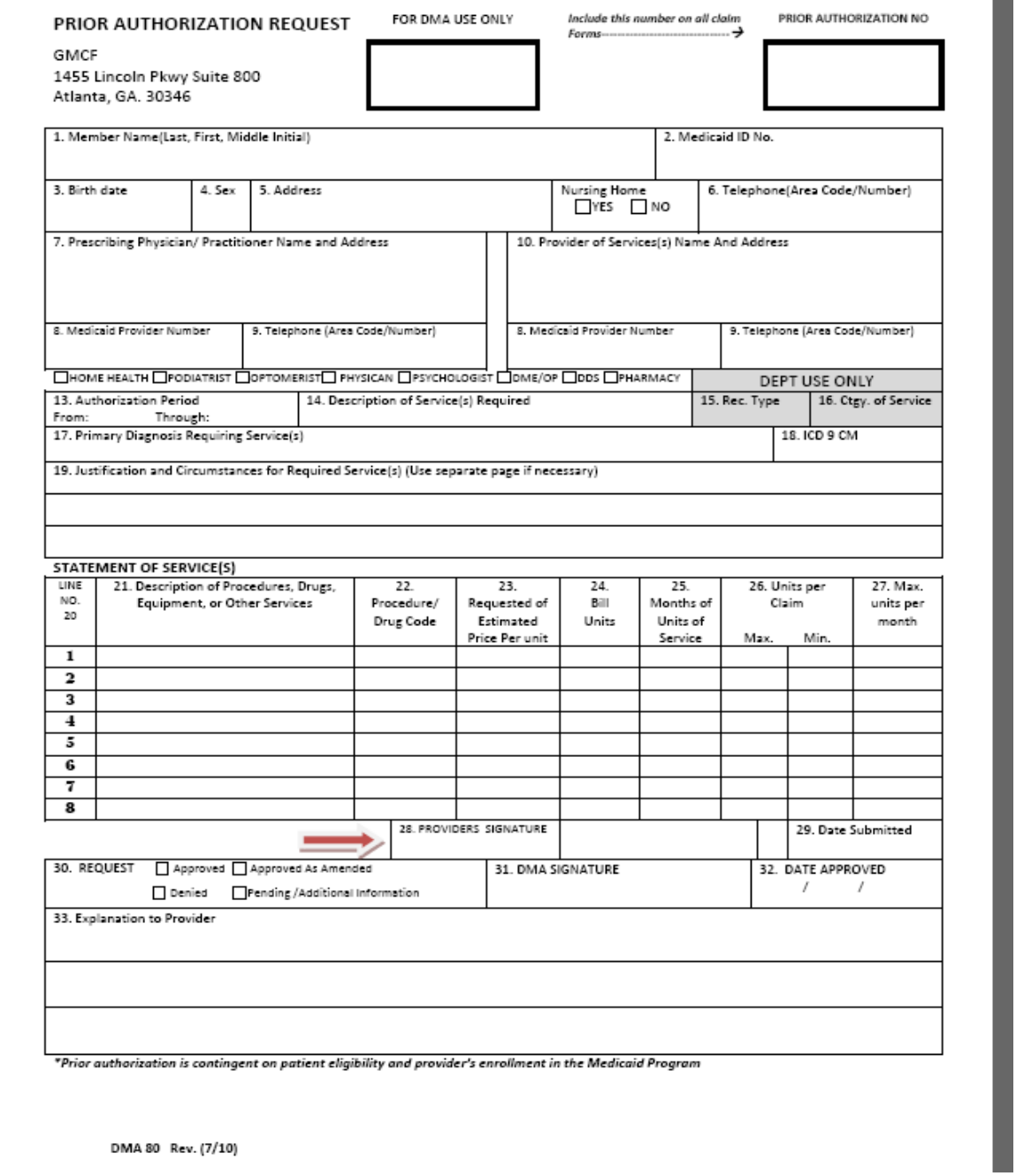
- Adding a location to my provider record
- Changing my provider information
- Written inquiries and correspondence
- E-mail and Contact Us inquiries

Appendix C Miscellaneous Forms and Attachments

This section contains examples of miscellaneous forms and attachments used for billing. Providers must refer to their specific Provider Contract, formerly known as COS, Part II Policies and Procedures Manual for detailed instructions on how to complete these forms. To view and print other DCH forms and attachments, visit the Gainwell Technologies Web Portal at www.mmis.georgia.gov, navigate to the Provider Information menu and select Forms from the available submenu.

C.1 Prior Authorization Request Form (DMA-80 or DMA-81)

As a condition of reimbursement, the Division requires that certain services or procedures be approved prior to the time they are rendered. This process is called Prior Approval. Prior Approval pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. Please refer to your Part II manual specific to the Provider Contract formerly known as the COS, for detail requirements.



PRIOR AUTHORIZATION REQUEST

GMCF
1455 Lincoln Pkwy Suite 800
Atlanta, GA. 30346

FOR DMA USE ONLY

Include this number on all claim Forms

PRIOR AUTHORIZATION NO

1. Member Name(Last, First, Middle Initial)				2. Medicaid ID No.
3. Birth date	4. Sex	5. Address	Nursing Home ☐YES ☐NO	6. Telephone(Area Code/Number)

7. Prescribing Physician/ Practitioner Name and Address		10. Provider of Services(s) Name And Address	
8. Medicaid Provider Number	9. Telephone (Area Code/Number)	8. Medicaid Provider Number	9. Telephone (Area Code/Number)

☐HOME HEALTH ☐PODIATRIST ☐OPTOMERIST ☐PHYSICAN ☐PSYCHOLOGIST ☐DME/OP ☐DDS ☐PHARMACY

DEPT USE ONLY

13. Authorization Period From: Through:	14. Description of Service(s) Required	15. Rec. Type	16. Ctgy. of Service
17. Primary Diagnosis Requiring Service(s)			18. ICD 9 CM
19. Justification and Circumstances for Required Service(s) (Use separate page if necessary)			

STATEMENT OF SERVICE(S)

LINE NO. 20	21. Description of Procedures, Drugs, Equipment, or Other Services	22. Procedure/ Drug Code	23. Requested of Estimated Price Per unit	24. Bill Units	25. Months of Units of Service	26. Units per Claim Max.	Min.	27. Max. units per month
1								
2								
3								
4								
5								
6								
7								
8								

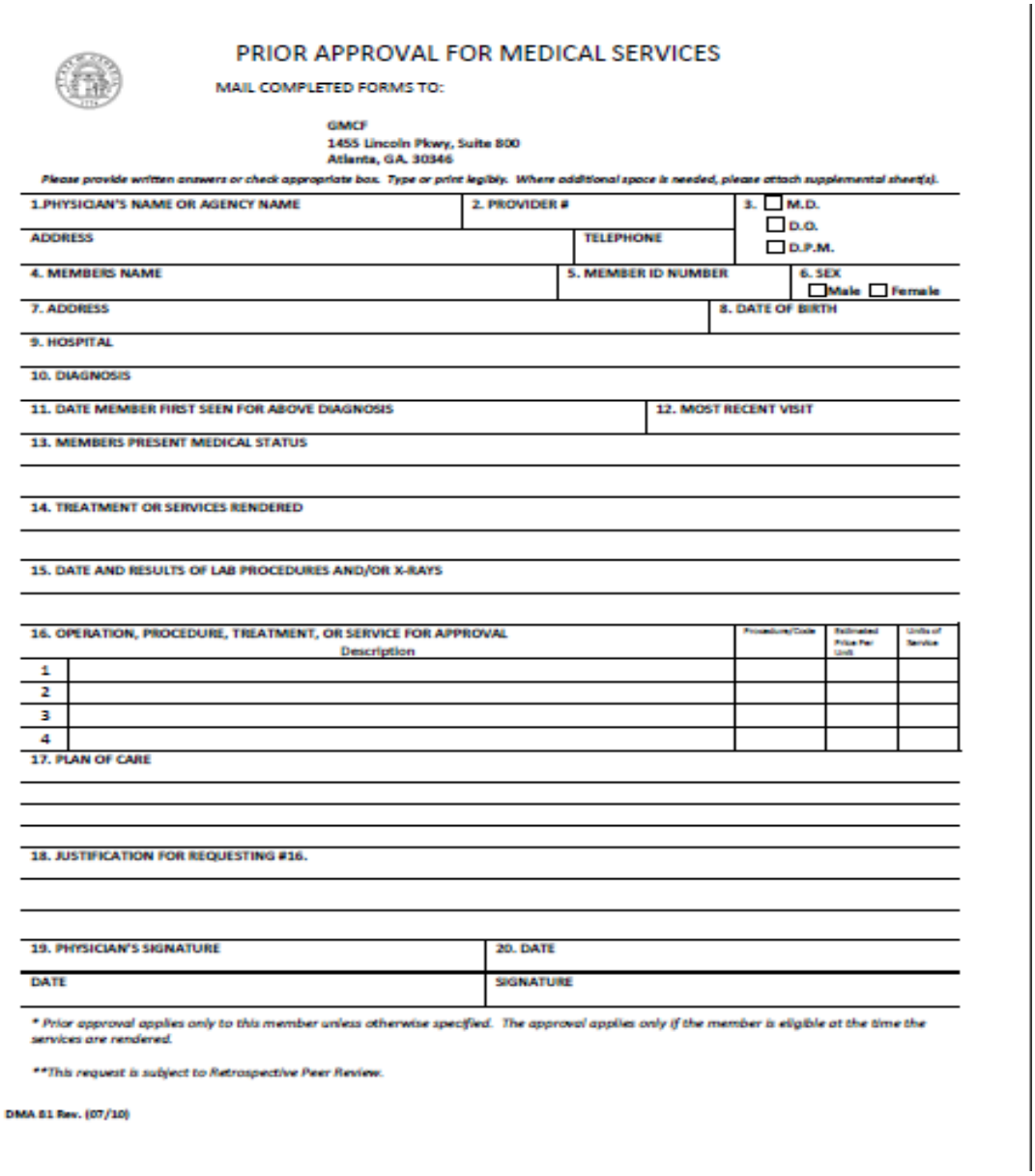
28. PROVIDERS SIGNATURE		29. Date Submitted

30. REQUEST ☐ Approved ☐ Approved As Amended ☐ Denied ☐ Pending /Additional Information	31. DMA SIGNATURE	32. DATE APPROVED / /
33. Explanation to Provider		

**Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program*

DMA 80 Rev. (7/10)

Figure 13: Prior Authorization Request Form (DMA-80)



PRIOR APPROVAL FOR MEDICAL SERVICES

MAIL COMPLETED FORMS TO:

GMCF
1455 Lincoln Pkwy, Suite 800
Atlanta, GA. 30346

Please provide written answers or check appropriate box. Type or print legibly. Where additional space is needed, please attach supplemental sheet(s).

1.PHYSICIAN'S NAME OR AGENCY NAME	2. PROVIDER #	3. ☐ M.D. ☐ D.O. ☐ D.P.M.
ADDRESS	TELEPHONE	
4. MEMBERS NAME	5. MEMBER ID NUMBER	6. SEX ☐ Male ☐ Female
7. ADDRESS	8. DATE OF BIRTH	

9. HOSPITAL

10. DIAGNOSIS

11. DATE MEMBER FIRST SEEN FOR ABOVE DIAGNOSIS	12. MOST RECENT VISIT

13. MEMBERS PRESENT MEDICAL STATUS

14. TREATMENT OR SERVICES RENDERED

15. DATE AND RESULTS OF LAB PROCEDURES AND/OR X-RAYS

	16. OPERATION, PROCEDURE, TREATMENT, OR SERVICE FOR APPROVAL Description	Procedure/Code	Estimated Price Per Unit	Units of Service
1				
2				
3				
4				

17. PLAN OF CARE

18. JUSTIFICATION FOR REQUESTING #16.

19. PHYSICIAN'S SIGNATURE	20. DATE
DATE	SIGNATURE

** Prior approval applies only to this member unless otherwise specified. The approval applies only if the member is eligible at the time the services are rendered.*

***This request is subject to Retrospective Peer Review.*

DMA 81 Rev. (07/10)

Figure 14: Prior Authorization Request Form (DMA-81)

C.2 Exceptional Transportation Prior Authorization Request Form (DMA-322)

The DCH guidelines set forth in the Policies and Procedures Manual, Part I, Section 203 and Part II, Chapter 800, of the Policies and Procedures for Exceptional Transportation Services manual discusses prior approval procedures and instructions for completing the form. DCH identifies services requiring prior approval.

When prior approval is requested, the coordinator of transportation services for DFCS or the non-emergency ambulance service provider must complete the Exceptional Transportation Prior Authorization Form, DMA-322.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

EXCEPTIONAL TRANSPORTATION

PRIOR AUTHORIZATION REQUEST*

Include this Number On All Claim Forms-----→	PRIOR APPROVAL NUMBER
Prior Approval Expires	

Mail Completed Forms To: GMCF, 1455 Lincoln Pkwy Suite 800, Atlanta, GA. 30346

Requested By:

1.TRANSPORTATION SERVICE PROVIDER NAME				2.PHONE (AREA CODE/NUMBER)
3.MAILING ADDRESS				
CITY	COUNTY	STATE	ZIP	4.PROVIDER MEDICAID NUMBER

Recipient Information:

5.RECIPIENT ADDRESS (LAST, FIRST, MIDDLE INITIAL)				6.RECIPIENT MEDICAID NUMBER
7. RECIPIENT ADDRESS	CITY	COUNTY	STATE	ZUP CODE
8.PHONE (Area Code/Number)	9.BIRTHDATE (MM/DD/YY)	10. AGE	11. SEX ☐Male ☐Female	
12. DIAGNOSIS (If Known)				

Health Care Provider Information:

13. HEALTH CARE PROVIDER NAME			14.PHONE (Area Code/Number)
15. HEALTH CARE PROVIDER ADDRESS	CITY	COUNTY	STATE ZIP CODE

Description of Service:

16. TRANSPORTATION SERVICE(S) REQUESTED (CHECK ALL THAT APPLY)

- ☐ CODE T2003 – U1 AUTOMOBILE (1ST PSGR)
- ☐ CODE T2003 – U1 AUTOMOBILE (2ND PSGR)
- ☐ CODE T2003 – U1 AUTOMOBILE (3RD PSGR)
- ☐ CODE A0100 – TAXI
- ☐ CODE A0190 – U1 TAXI (Non-Local)
- ☐ CODE T2004 – CITY TRANSIT
- ☐ CODE T2001 – ESCORT
- ☐ CODE T2002 – OTHER
- ☐ CODE A0110 – COMMERICAL BUS OR TRAIN(INTERSTATE)
- ☐ CODE A0140 – AIRPLANE
- ☐ CODE A0170 – PARKING/TOLLS FEE
- ☐ CODE A0190 – Meals (MEMBER OUT-OF-STATE)
- ☐ CODE A0190 – U1 Meals (MEMBER IN-STATE)
- ☐ CODE A0180 – LODGING (MEMBER OUT-OF-STATE)
- ☐ CODE A0180 – U1 LODGING (MEMBER IN-STATE)
- ☐ CODE A0210 – MEALS (ESCORT OUT-OF-STATE)
- ☐ CODE A0210 – U1 MEALS (ESCORT-IN-STATE)
- ☐ CODE A0200 – LODGING (ESCORT OUT-OF-STATE)
- ☐ CODE A2000 – U1 LODGING (ESCORT IN-STATE)

17. CHECK ONE	18. CHECK ONE
☐ ONE WAY	☐ RECIPIENT ONLY
☐ ROUND TRIP	☐ RECIPIENT & ONE ESCORT

19. NO. OF TRIPS	20. NO. OF MILES	21. LENGTH OF STAY DAYS	22. DATE(S) OF SERVICE FROM: / / THROUGH / /	23. AMOUNT

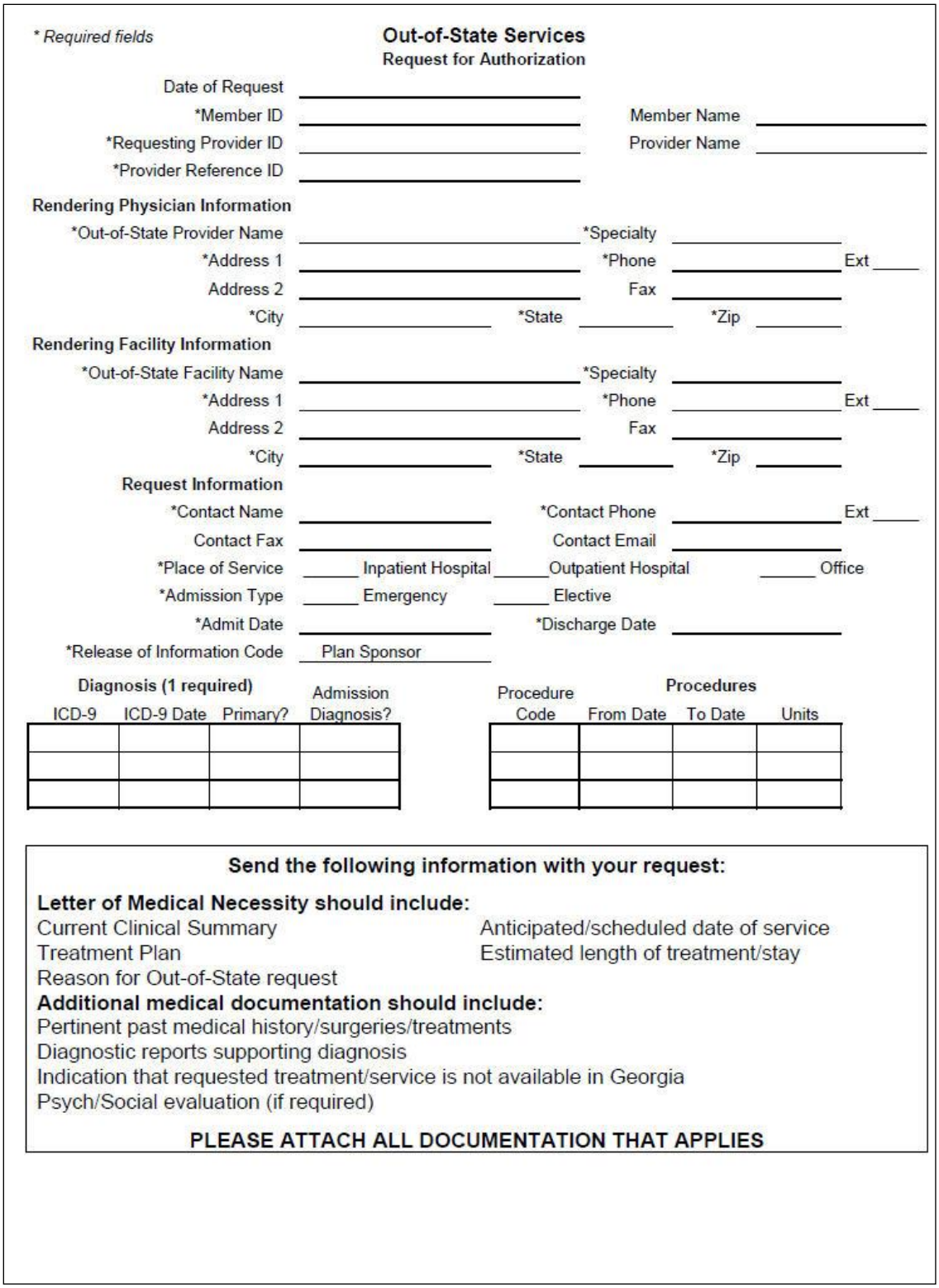
24. CIRCUMSTANCES AND/OR JUSTIFICATION FOR REQUESTED SERVICES:

25. COMMENTS

DMA USE ONLY	26. APPROVED ☐	OR	27. DENIED ☐	28. REASON DENIED
	29. SIGNATURE		30. DATE	*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of Service.*

DMA-322 Rev. (7/10)

Figure 15: Exceptional Transportation Prior Authorization Request Form (DMA-322)



* *Required fields*

Out-of-State Services
Request for Authorization

Date of Request _____

*Member ID _____ Member Name _____

*Requesting Provider ID _____ Provider Name _____

*Provider Reference ID _____

Rendering Physician Information

*Out-of-State Provider Name _____ *Specialty _____

*Address 1 _____ *Phone _____ Ext ____

Address 2 _____ Fax _____

*City _____ *State _____ *Zip _____

Rendering Facility Information

*Out-of-State Facility Name _____ *Specialty _____

*Address 1 _____ *Phone _____ Ext ____

Address 2 _____ Fax _____

*City _____ *State _____ *Zip _____

Request Information

*Contact Name _____ *Contact Phone _____ Ext ____

Contact Fax _____ Contact Email _____

*Place of Service _____ Inpatient Hospital _____ Outpatient Hospital _____ Office

*Admission Type _____ Emergency _____ Elective

*Admit Date _____ *Discharge Date _____

*Release of Information Code Plan Sponsor

Diagnosis (1 required)

ICD-9	ICD-9 Date	Primary?	Admission Diagnosis?

Procedures

Procedure Code	From Date	To Date	Units

Send the following information with your request:

Letter of Medical Necessity should include:

Current Clinical Summary
Treatment Plan
Reason for Out-of-State request
Anticipated/scheduled date of service
Estimated length of treatment/stay

Additional medical documentation should include:

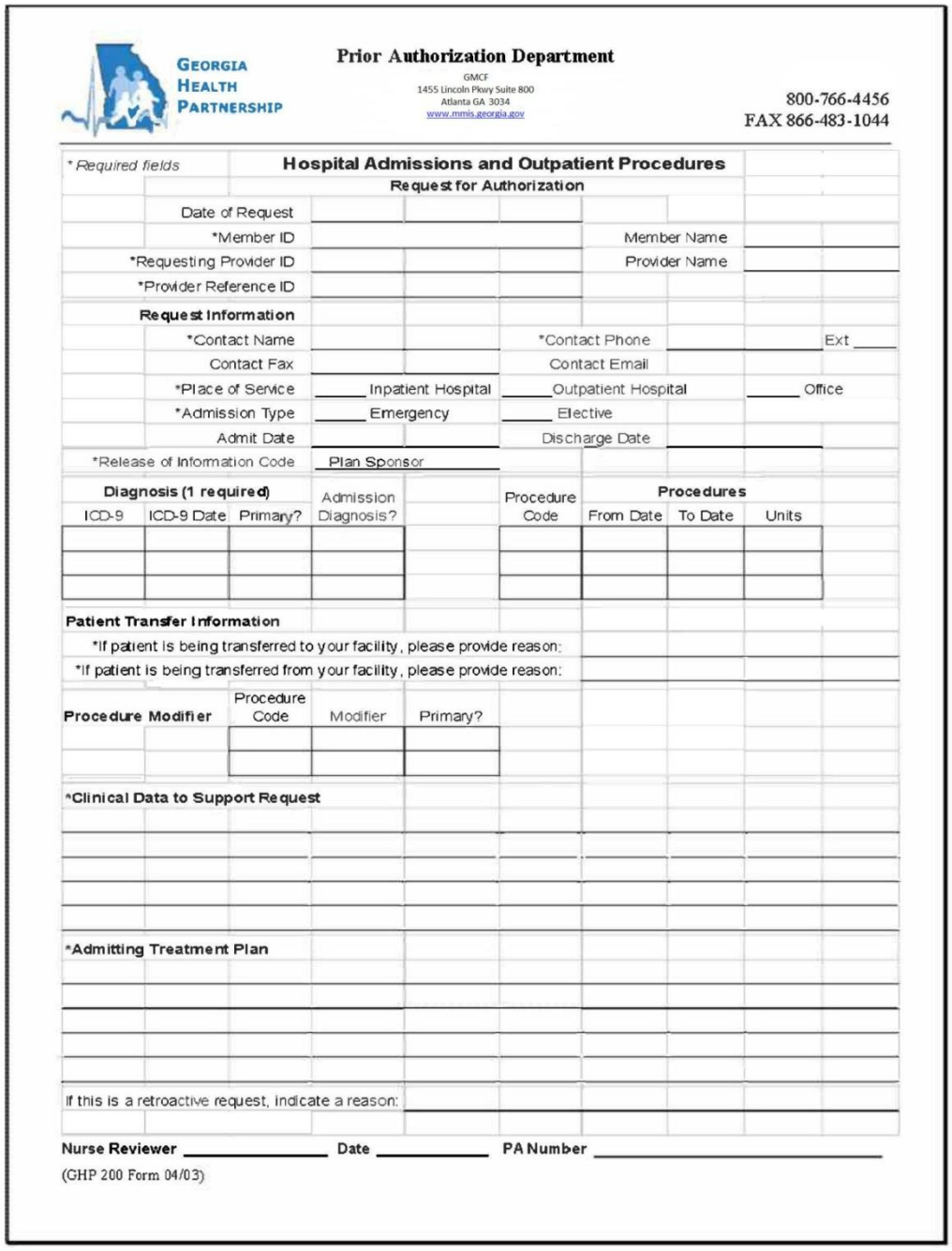
Pertinent past medical history/surgeries/treatments
Diagnostic reports supporting diagnosis
Indication that requested treatment/service is not available in Georgia
Psych/Social evaluation (if required)

PLEASE ATTACH ALL DOCUMENTATION THAT APPLIES

Figure 16: Out of State Services Request for Authorization

C.3 GHP 200 Request for Authorization

The GHP 200 Request for Authorization form is to be completed by the physician in requesting prior authorization for a procedure performed in either an outpatient hospital or inpatient hospital setting.



GEORGIA HEALTH PARTNERSHIP

Prior Authorization Department

GMCF
1455 Lincoln Pkwy Suite 800
Atlanta GA 3034
www.mmis.georgia.gov

800-766-4456
FAX 866-483-1044

*Required fields

Hospital Admissions and Outpatient Procedures
Request for Authorization

Date of Request
*Member ID — Member Name
*Requesting Provider ID — Provider Name
*Provider Reference ID

Request Information

*Contact Name — *Contact Phone — Ext
Contact Fax — Contact Email
*Place of Service ____ Inpatient Hospital ____ Outpatient Hospital ____ Office
*Admission Type ____ Emergency ____ Elective
Admit Date — Discharge Date
*Release of Information Code Plan Sponsor

Diagnosis (1 required)			Admission	Procedure	Procedures		
ICD-9	ICD-9 Date	Primary?	Diagnosis?	Code	From Date	To Date	Units

Patient Transfer Information

*If patient is being transferred to your facility, please provide reason:
*If patient is being transferred from your facility, please provide reason:

Procedure Modifier	Procedure Code	Modifier	Primary?

*Clinical Data to Support Request

*Admitting Treatment Plan

If this is a retroactive request, indicate a reason:

Nurse Reviewer _____ **Date** _____ **PA Number** _____

(GHP 200 Form 04/03)

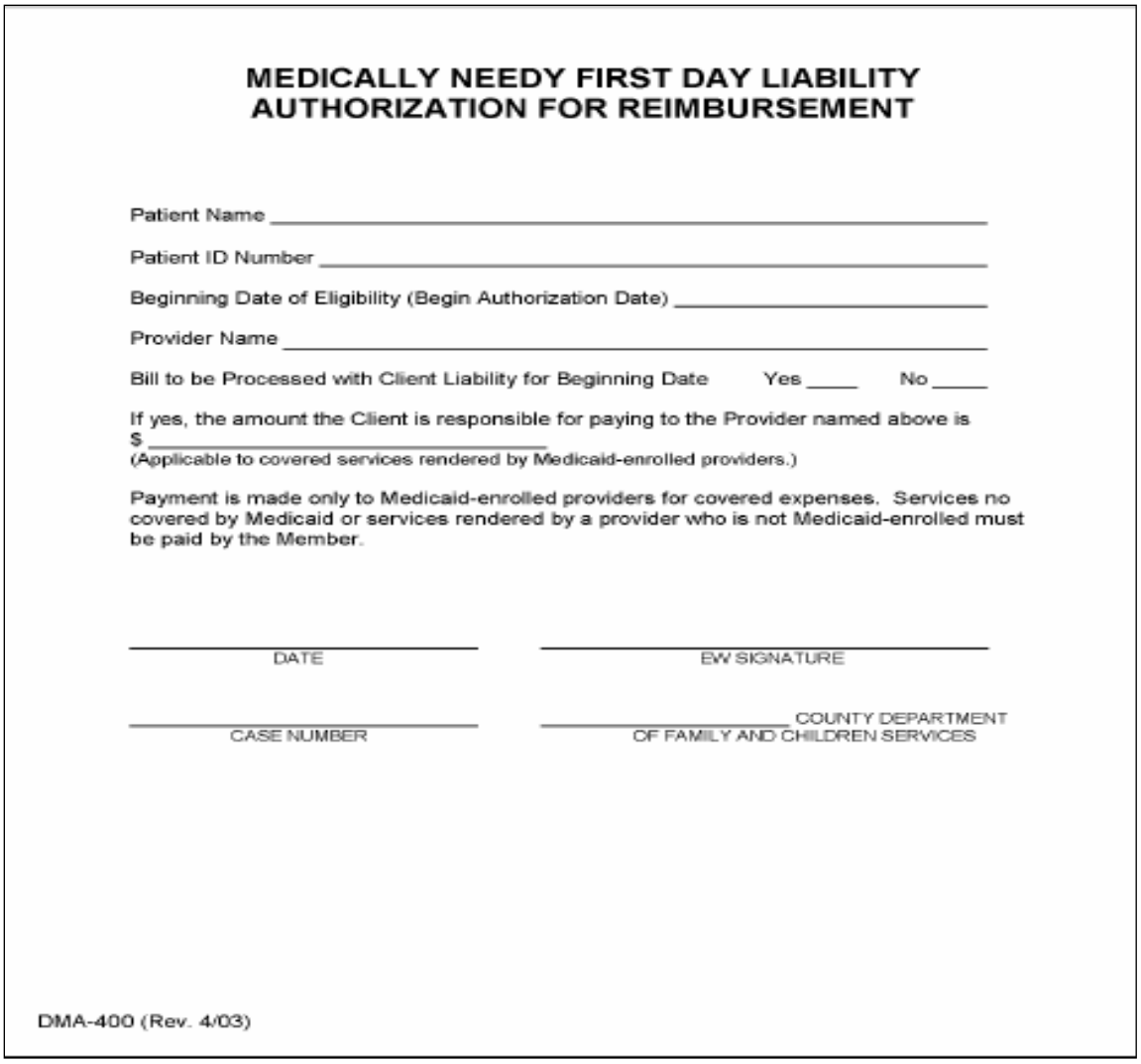
Figure 17: GHP 200 Request for Authorization

C.4 Medically Needy Spenddown Form (DMA-400)

The DMA-400 form is completed by DFCS for services rendered to medically needy members on the same date as the beginning date of eligibility. The form identifies the spenddown amount of first day liability, which is payable to the provider by the member.

What is the Medically Needy Spenddown Program?

The Medically Needy program covers children under age 18, pregnant women, aged, blind, and disabled persons who otherwise are not Medicaid eligible because of income. Their monthly income may exceed the Medicaid payment income eligibility standard and would result in these individuals having to pay for a prescribed amount of their healthcare before they are eligible for Medicaid.



MEDICALLY NEEDY FIRST DAY LIABILITY
AUTHORIZATION FOR REIMBURSEMENT

Patient Name _____

Patient ID Number _____

Beginning Date of Eligibility (Begin Authorization Date) _____

Provider Name _____

Bill to be Processed with Client Liability for Beginning Date Yes ____ No ____

If yes, the amount the Client is responsible for paying to the Provider named above is $ _____
(Applicable to covered services rendered by Medicaid-enrolled providers.)

Payment is made only to Medicaid-enrolled providers for covered expenses. Services no covered by Medicaid or services rendered by a provider who is not Medicaid-enrolled must be paid by the Member.

_____ DATE

_____ EW SIGNATURE

_____ CASE NUMBER

_____ COUNTY DEPARTMENT OF FAMILY AND CHILDREN SERVICES

DMA-400 (Rev. 4/03)

Figure 18: Medically Needy Spenddown Form (DMA-400)

If the statement on the DMA-962 form reads, "DMA-Form 400 required" and if the beginning date of eligibility is equal to the DOS or within the span of dates of service, the DMA-400 form must be attached to the submitted claim for payment. If not attached, the claim is rejected or denied to the provider, with an error message stating that the DMA-400 form is required before the claim can be processed.

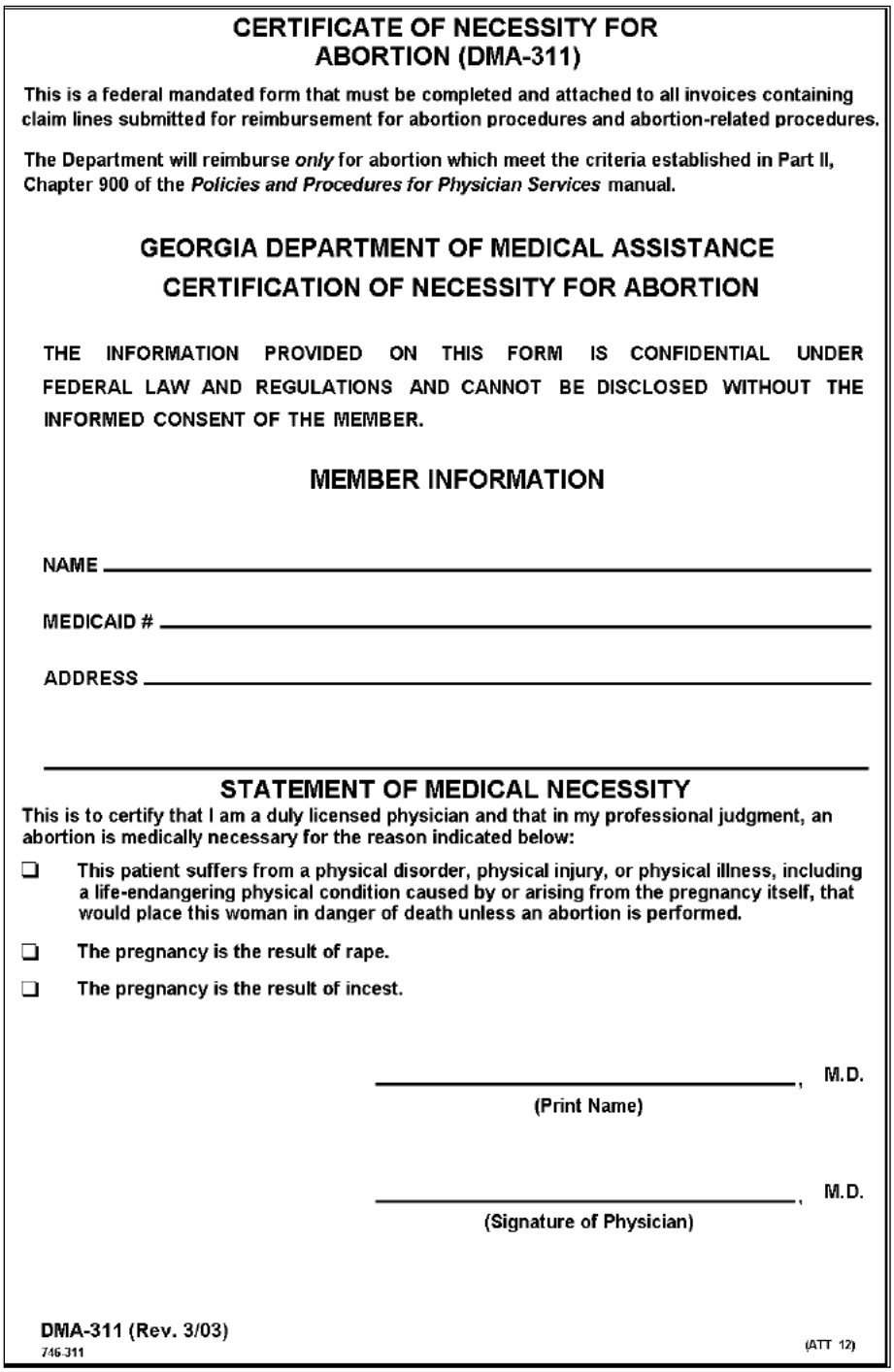
The DMA-400 form is completed by DFCS for services rendered to Medically Needy Members on the same date as the beginning date of eligibility. The form identifies the spenddown amount of first day liability, which is payable to the provider by the member.

This amount could be zero; however, the DMA-400 form must be submitted for payment.

Note: Do not deduct the first day liability amount that appears on Form 400 from submitted charges. If you have any questions about eligibility or the DMA-400 form, contact the member or your county DFCS office.

C.5 Certification of Necessity for Abortion Form (DMA-311)

The Certification of Necessity for Abortion form is required when filing a claim for an abortion procedure and should be submitted as a hard copy with the appropriate supporting documentation.



CERTIFICATE OF NECESSITY FOR ABORTION (DMA-311)

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse *only* for abortion which meet the criteria established in Part II, Chapter 900 of the *Policies and Procedures for Physician Services* manual.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
CERTIFICATION OF NECESSITY FOR ABORTION

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE MEMBER.

MEMBER INFORMATION

NAME _____

MEDICAID # _____

ADDRESS _____

STATEMENT OF MEDICAL NECESSITY

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

- ❑ This patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place this woman in danger of death unless an abortion is performed.
- ❑ The pregnancy is the result of rape.
- ❑ The pregnancy is the result of incest.

_____, M.D.
(Print Name)

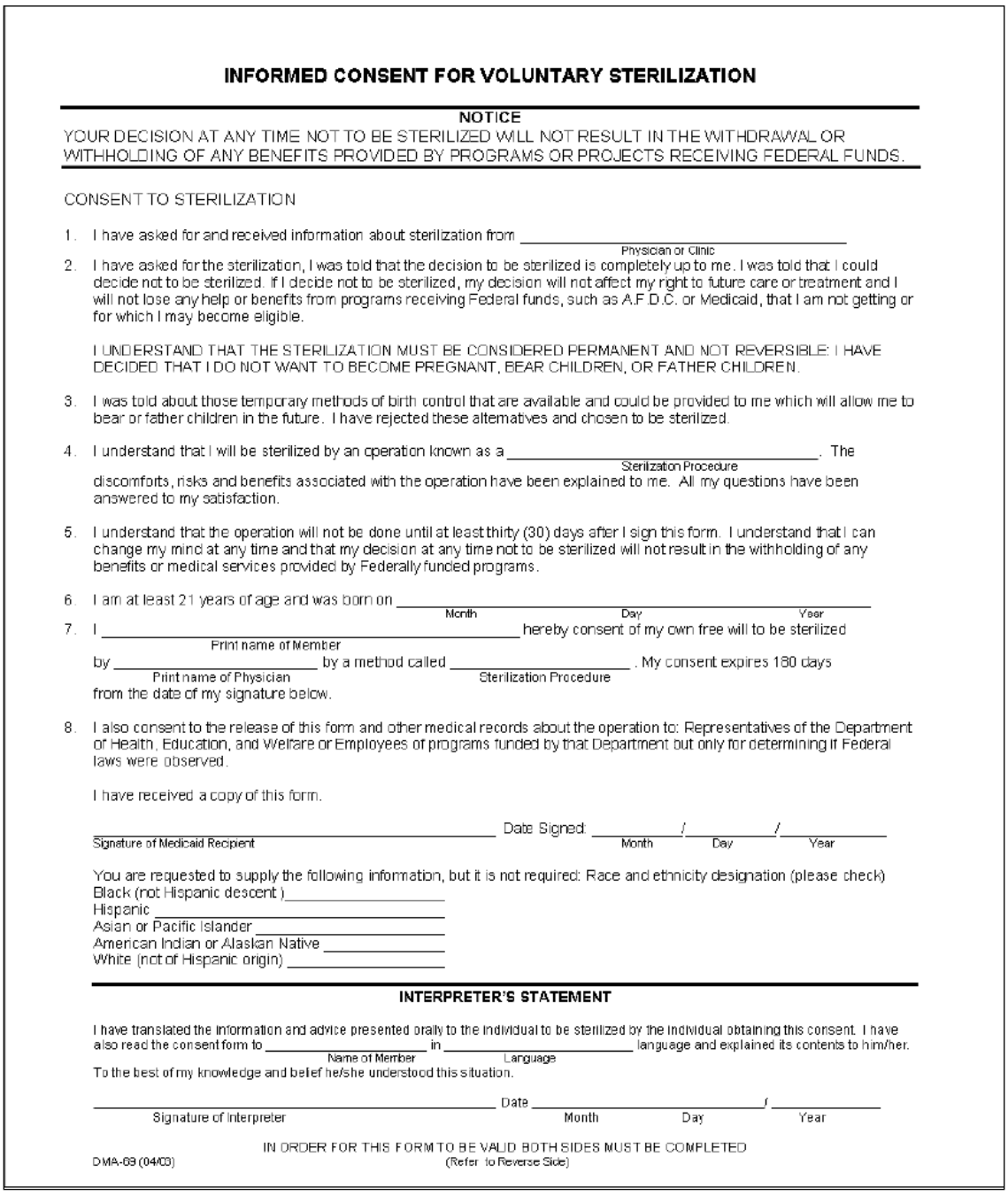
_____, M.D.
(Signature of Physician)

DMA-311 (Rev. 3/03)
746-311
(ATT 12)

Figure 19: Certification of Necessity for Abortion Form (DMA-311)

C.6 Informed Consent for Voluntary Sterilization Form (DMA-69)

This form is required whenever submitting a claim for voluntary sterilization and should be submitted as a hard copy with the appropriate supporting documentation. For specific instructions on completing the sterilization form, please refer to the Part II Policy and Procedures Manual.



INFORMED CONSENT FOR VOLUNTARY STERILIZATION

NOTICE

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

1. I have asked for and received information about sterilization from _____ (Physician or Clinic)
2. I have asked for the sterilization, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment and I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid, that I am not getting or for which I may become eligible.

   I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE: I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.
3. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father children in the future. I have rejected these alternatives and chosen to be sterilized.
4. I understand that I will be sterilized by an operation known as a _____ (Sterilization Procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
5. I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.
6. I am at least 21 years of age and was born on _____ (Month) _____ (Day) _____ (Year)
7. I _____ (Print name of Member) hereby consent of my own free will to be sterilized by _____ (Print name of Physician) by a method called _____ (Sterilization Procedure). My consent expires 180 days from the date of my signature below.
8. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs funded by that Department but only for determining if Federal laws were observed.

   I have received a copy of this form.

_____ (Signature of Medicaid Recipient) Date Signed: _____ (Month) / _____ (Day) / _____ (Year)

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)
Black (not Hispanic descent) _____
Hispanic _____
Asian or Pacific Islander _____
American Indian or Alaskan Native _____
White (not of Hispanic origin) _____

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to _____ (Name of Member) in _____ (Language) language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this situation.

_____ (Signature of Interpreter) Date _____ (Month) / _____ (Day) / _____ (Year)

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED
(Refer to Reverse Side)

DMA-69 (04/03)

Figure 20: Informed Consent for Voluntary Sterilization Form (DMA-69)

FOR FISCAL AGENT USE ONLY

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed this consent form, I explained to him/her the nature of the
Name Of Member
sterilization operation, _____, the fact that it is intended to be a final and
Sterilization Procedure
irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature Of Person Obtaining Consent

Date

Facility

Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on
Name of Member
_____, I explained to him/her the nature of the sterilization operation
Date Of Operation
_____, the fact that it is intended to be a final and irreversible procedure and
Sterilization Procedure
the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPH: NUMBER (1) OR NUMBER (2)
(Cross out the paragraph which is not used.)

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used.

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's date of expected delivery _____

☐ Emergency abdominal surgery (describe circumstances): _____

_____

_____

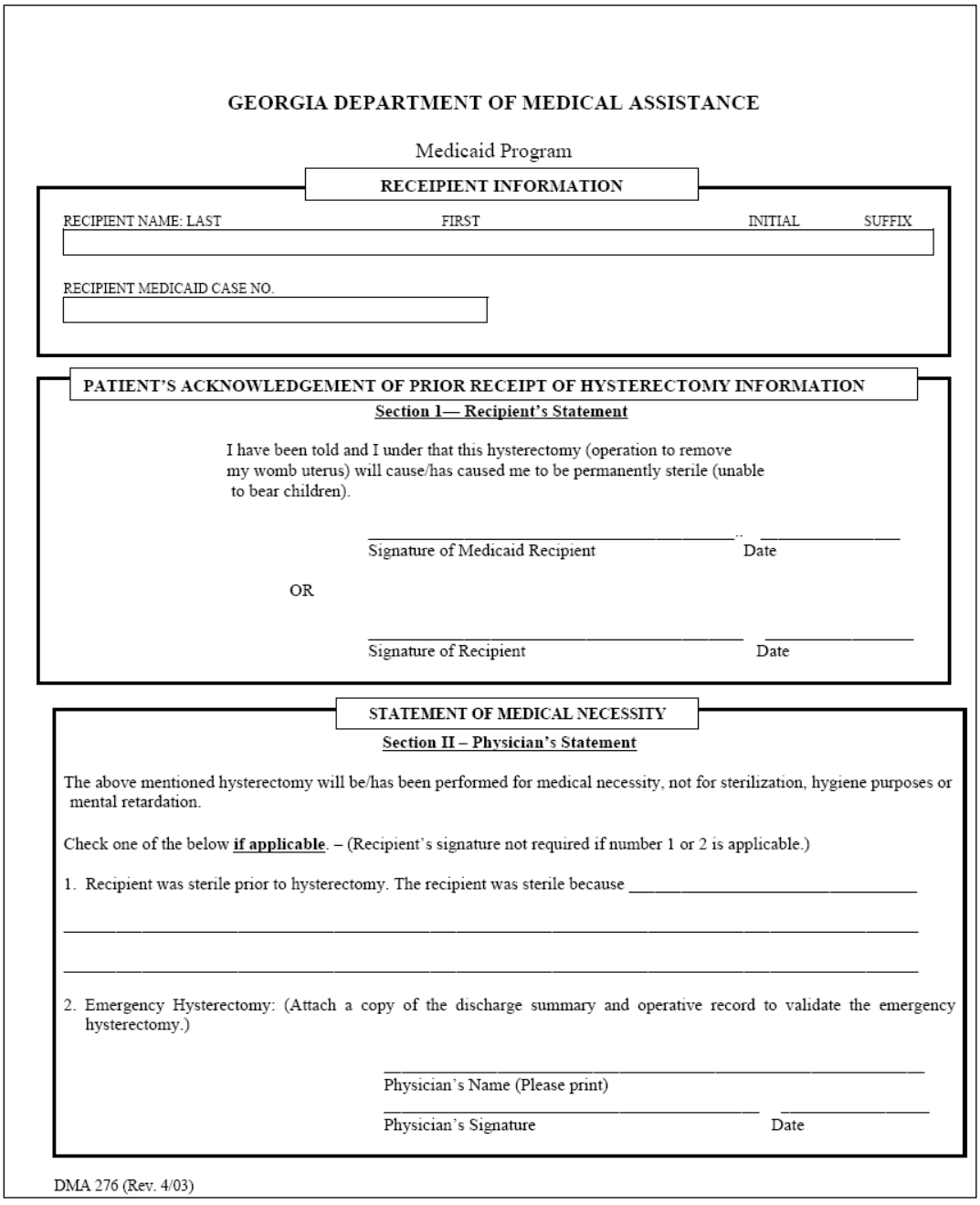
Physician's Signature _____ Date _____

DMA-69 (04/03)

Figure 21: Informed Consent for Voluntary Sterilization Form (DMA-69)(Back)

C.7 Acknowledgement of Prior Receipt of Hysterectomy Information Form (DMA-276)

This form is required for every hysterectomy procedure and should be submitted as a hard copy with the appropriate supporting documentation. For specific instructions on completing the sterilization form, please refer to the Part II Policy and Procedures Manual.



GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Medicaid Program

RECEIPIENT INFORMATION

RECIPIENT NAME: LAST FIRST INITIAL SUFFIX

RECIPIENT MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section 1— Recipient's Statement

I have been told and I under that this hysterectomy (operation to remove my womb uterus) will cause/has caused me to be permanently sterile (unable to bear children).

Signature of Medicaid Recipient Date

OR

Signature of Recipient Date

STATEMENT OF MEDICAL NECESSITY

Section II – Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable**. – (Recipient's signature not required if number 1 or 2 is applicable.)

1. Recipient was sterile prior to hysterectomy. The recipient was sterile because _____

2. Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

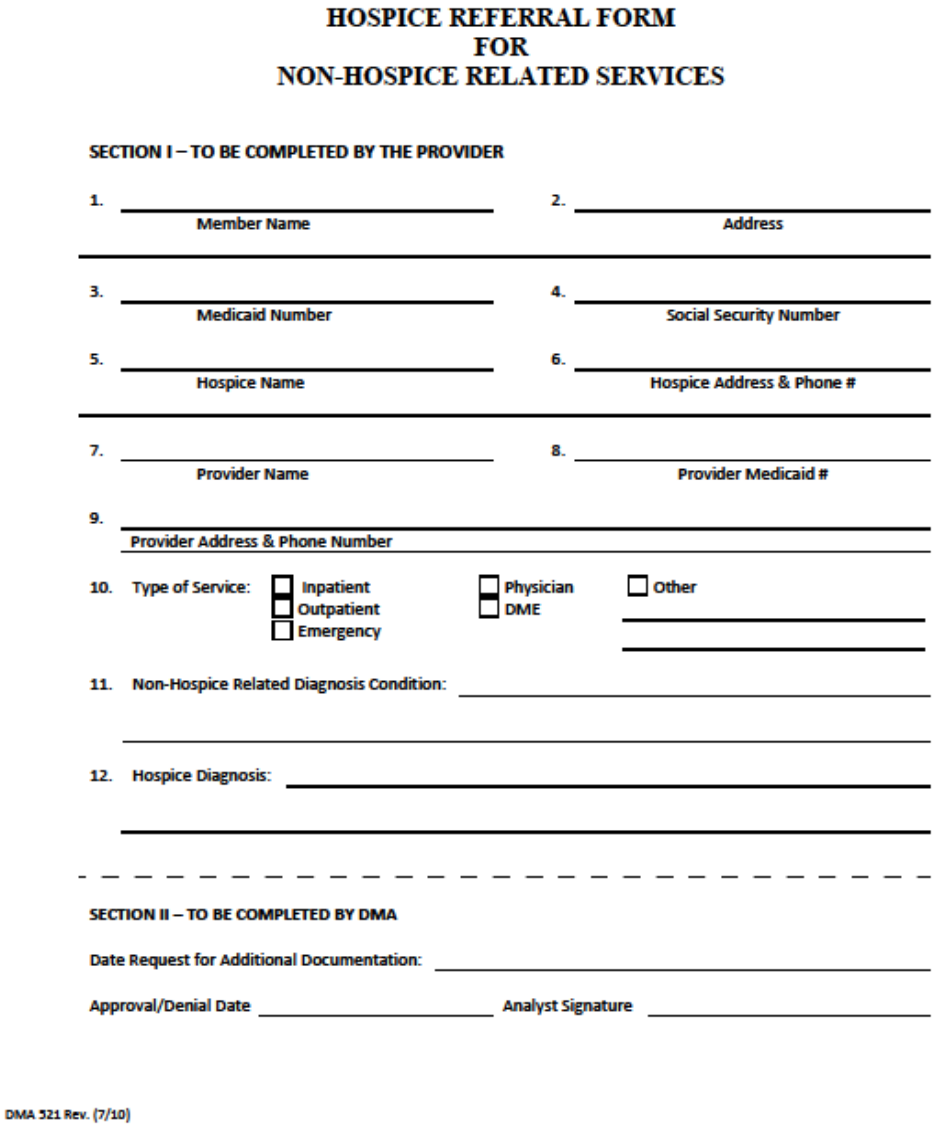
Physician's Name (Please print)

Physician's Signature Date

DMA 276 (Rev. 4/03)

Figure 22: Acknowledgement of Prior Receipt of Hysterectomy Information Form (DMA-276)

C.8 Hospice Referral Form (DMA-521)



HOSPICE REFERRAL FORM
FOR
NON-HOSPICE RELATED SERVICES

SECTION I – TO BE COMPLETED BY THE PROVIDER

1. _____ Member Name
2. _____ Address
3. _____ Medicaid Number
4. _____ Social Security Number
5. _____ Hospice Name
6. _____ Hospice Address & Phone #
7. _____ Provider Name
8. _____ Provider Medicaid #
9. _____ Provider Address & Phone Number
10. Type of Service: ☐ Inpatient ☐ Outpatient ☐ Emergency ☐ Physician ☐ DME ☐ Other _____
11. Non-Hospice Related Diagnosis Condition: _____
12. Hospice Diagnosis: _____

SECTION II – TO BE COMPLETED BY DMA

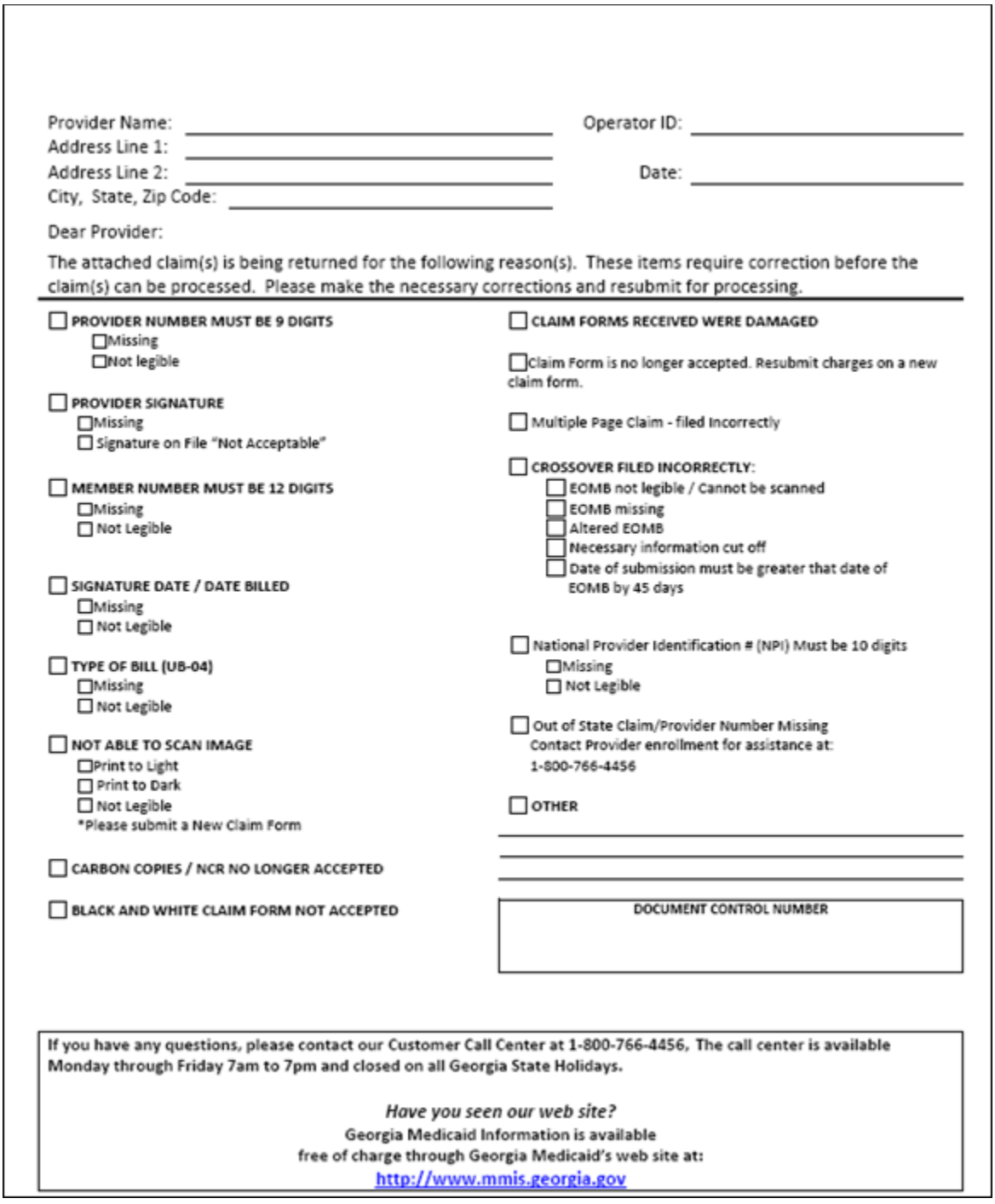
Date Request for Additional Documentation: _____

Approval/Denial Date _____ Analyst Signature _____

DMA 321 Rev. (7/10)

Figure 23: Hospice Referral Form

C.9 Mail Room Return To Provider Letter



Provider Name: _____ Operator ID: _____
Address Line 1: _____
Address Line 2: _____ Date: _____
City, State, Zip Code: _____

Dear Provider:

The attached claim(s) is being returned for the following reason(s). These items require correction before the claim(s) can be processed. Please make the necessary corrections and resubmit for processing.

- ☐ **PROVIDER NUMBER MUST BE 9 DIGITS**
  - ☐ Missing
  - ☐ Not legible
- ☐ **PROVIDER SIGNATURE**
  - ☐ Missing
  - ☐ Signature on File "Not Acceptable"
- ☐ **MEMBER NUMBER MUST BE 12 DIGITS**
  - ☐ Missing
  - ☐ Not Legible
- ☐ **SIGNATURE DATE / DATE BILLED**
  - ☐ Missing
  - ☐ Not Legible
- ☐ **TYPE OF BILL (UB-04)**
  - ☐ Missing
  - ☐ Not Legible
- ☐ **NOT ABLE TO SCAN IMAGE**
  - ☐ Print to Light
  - ☐ Print to Dark
  - ☐ Not Legible
  - *Please submit a New Claim Form
- ☐ **CARBON COPIES / NCR NO LONGER ACCEPTED**
- ☐ **BLACK AND WHITE CLAIM FORM NOT ACCEPTED**
- ☐ **CLAIM FORMS RECEIVED WERE DAMAGED**
- ☐ Claim Form is no longer accepted. Resubmit charges on a new claim form.
- ☐ Multiple Page Claim - filed Incorrectly
- ☐ **CROSSOVER FILED INCORRECTLY:**
  - ☐ EOMB not legible / Cannot be scanned
  - ☐ EOMB missing
  - ☐ Altered EOMB
  - ☐ Necessary information cut off
  - ☐ Date of submission must be greater that date of EOMB by 45 days
- ☐ National Provider Identification # (NPI) Must be 10 digits
  - ☐ Missing
  - ☐ Not Legible
- ☐ Out of State Claim/Provider Number Missing
  Contact Provider enrollment for assistance at:
  1-800-766-4456
- ☐ **OTHER**

_____
_____
_____

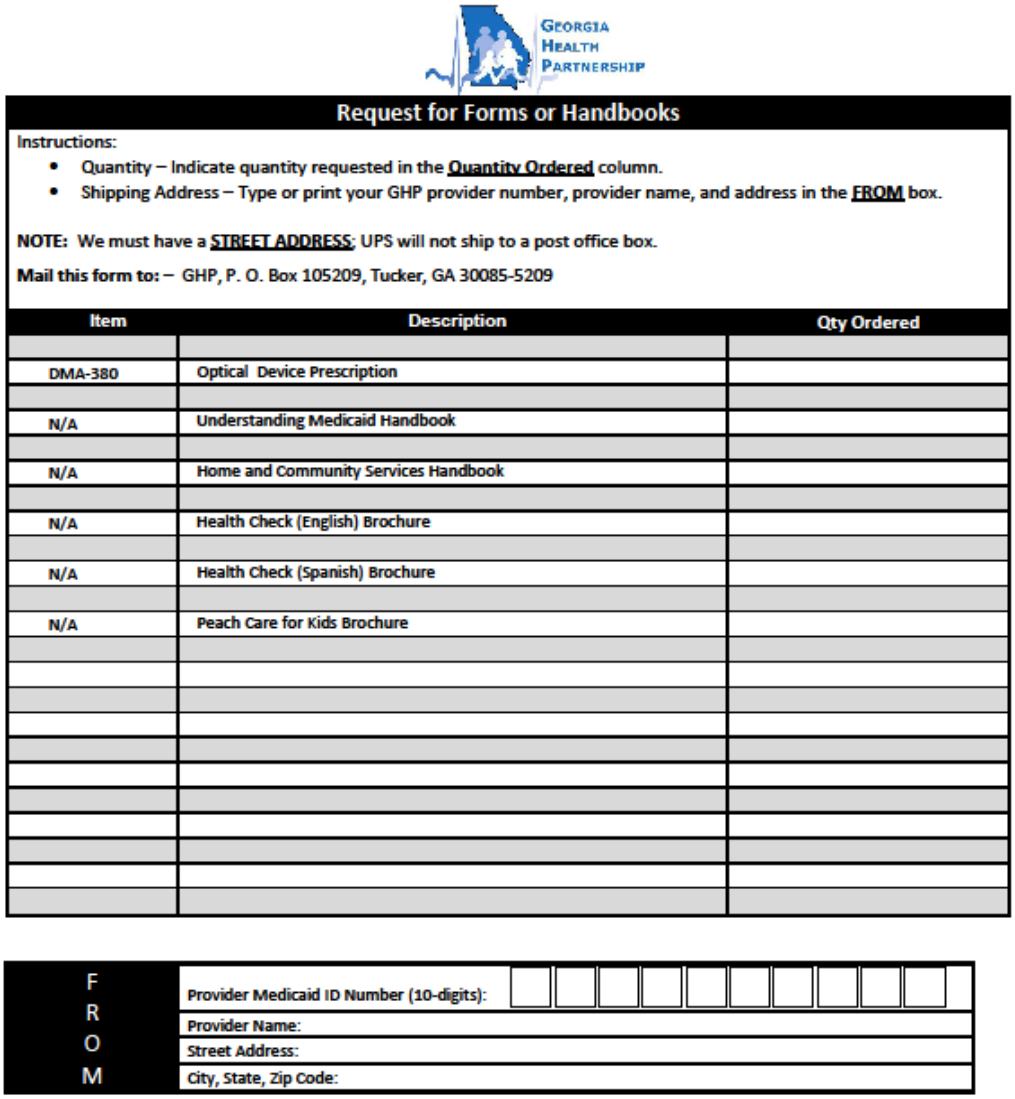
DOCUMENT CONTROL NUMBER

If you have any questions, please contact our Customer Call Center at 1-800-766-4456, The call center is available Monday through Friday 7am to 7pm and closed on all Georgia State Holidays.

Have you seen our web site?
Georgia Medicaid Information is available
free of charge through Georgia Medicaid's web site at:
http://www.mmis.georgia.gov

Figure 24: Mail Room Return To Provider Letter

C.10 Request for Forms



GEORGIA HEALTH PARTNERSHIP

Request for Forms or Handbooks

Instructions:

- Quantity – Indicate quantity requested in the **Quantity Ordered** column.
- Shipping Address – Type or print your GHP provider number, provider name, and address in the **FROM** box.

NOTE: We must have a **STREET ADDRESS**; UPS will not ship to a post office box.

Mail this form to: – GHP, P. O. Box 105209, Tucker, GA 30085-5209

Item	Description	Qty Ordered
DMA-380	Optical Device Prescription	
N/A	Understanding Medicaid Handbook	
N/A	Home and Community Services Handbook	
N/A	Health Check (English) Brochure	
N/A	Health Check (Spanish) Brochure	
N/A	Peach Care for Kids Brochure	

FROM	
	Provider Medicaid ID Number (10-digits):
	Provider Name:
	Street Address:
	City, State, Zip Code:

DMA 292 Rev. (01/11)

Figure 25: Request for Forms (DMA-292)

C.11 Attachment Form for Electronically Submitted Claims

Most attachments for Web Portal claims can be attached using the Web Portal. If unable to submit attachments electronically, providers should use the following form when using one of the methods below:

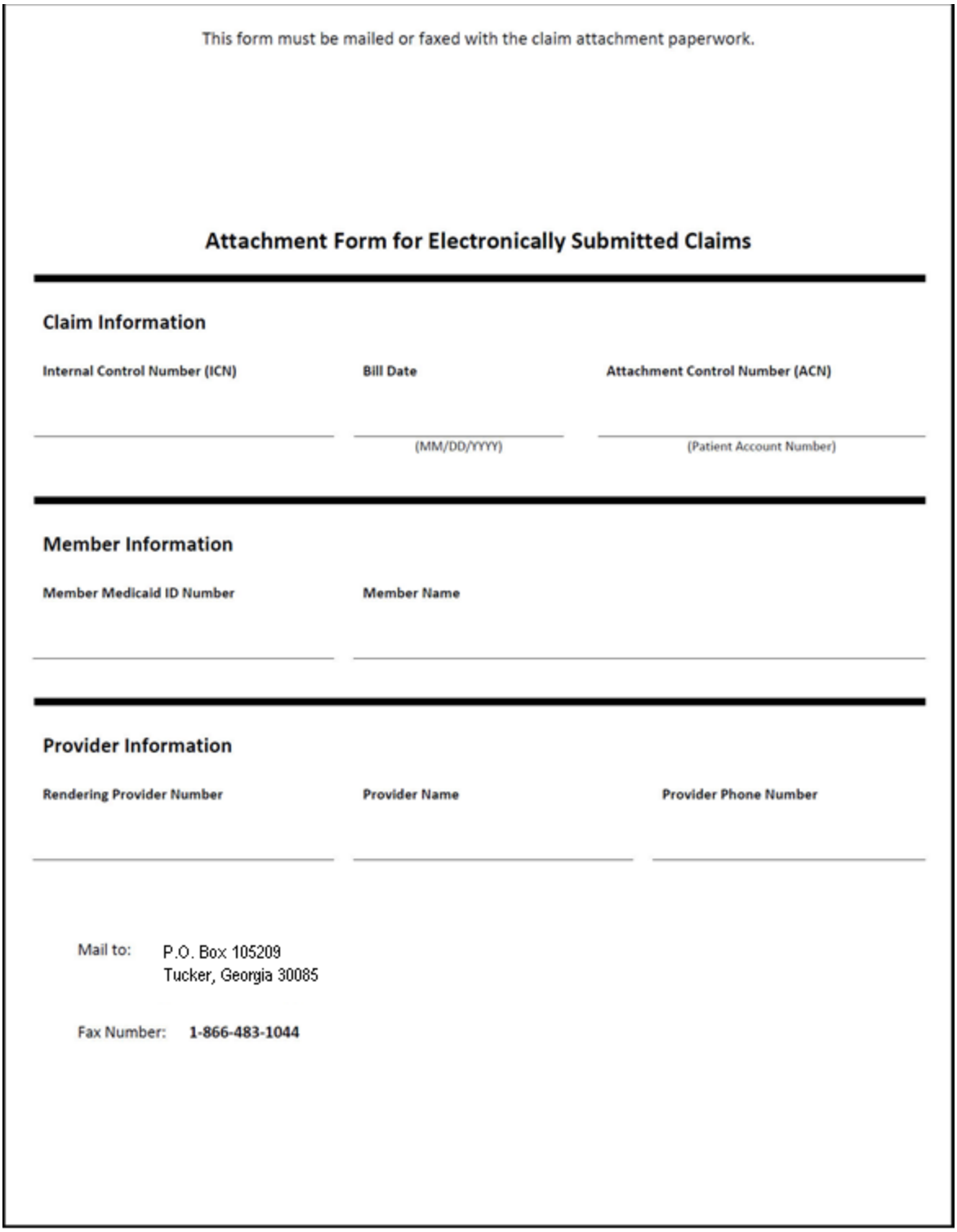
1. Provider Electronic Solutions (PES) software

2. Remote Access Server (RAS) for dial-up

3. Diskette/CD-ROM/tape

4. DVD

5. Value Added Network (VAN)



This form must be mailed or faxed with the claim attachment paperwork.

Attachment Form for Electronically Submitted Claims

Claim Information

Internal Control Number (ICN) _____

Bill Date _____ (MM/DD/YYYY)

Attachment Control Number (ACN) _____ (Patient Account Number)

Member Information

Member Medicaid ID Number _____

Member Name _____

Provider Information

Rendering Provider Number _____

Provider Name _____

Provider Phone Number _____

Mail to: P.O. Box 105209
Tucker, Georgia 30085

Fax Number: **1-866-483-1044**

Figure 26: Attachment Form for Electronically Submitted Claims

Appendix D HIPAA Attachment Codes

Effective November 1, 2010, the following HIPAA attachment codes have replaced the previous attachment codes that were being assigned to those claims that required an attachment for claims' processing. The "Old Attachment Code" column identifies those attachment codes previously used. "HIPAA Attachment Codes" column identifies the replaced attachment codes. Also included in this column is a brief description of the HIPAA attachment code. The "Comments" column explains the type of attachment that is not self-explanatory and need further clarification.

Attachment Codes Crosswalk

Old Attachment Code	HIPAA Attachment Code	Comments
04	AS Admission Summary	History & Physical or progress notes
05		
12		
04	B3 Physician Order	
21	B4 Referral Form	Hospice Referral form, Revocation Form, Election Form, Hospice Discharge Form, Hospice Transfer Form, Hospice Physician Certification & Recertification Form
01	CT Certification	DMA-962, DMA-400 (DFCS issued letter), Temporary Medicaid Certification Form, Supplemental Security Income Letter, DMA-304, Death Certificate
05		
12		
14		
21		
04	DA Dental Models	
04	DS Discharge Summary	
05		
12		
06	EB Explanation of Benefits	EOMB, TPL, Remittance Advice
09		
11		
04	NN Nursing Notes	

Old Attachment Code	HIPAA Attachment Code	Comments
04	OB Operative Notes	
05		
12		
04	OZ Support Data for Claim	This can be any miscellaneous documentation needed to support processing a claim
05		
12		
21		
04	RB Radiology Films	
04	RR Radiology Reports	
04	RT Report of Test and Analysis	
Note: If you are unable to find the appropriate attachment code for documentation being submitted as an attachment, please use "OZ".		

Glossary

270/271 (*Eligibility/Benefit Inquiry/Response)*: The Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine: a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and b) verify the health care eligibility and/or benefit information about that subscriber and/or dependent(s). The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits. These are X-12 transactions mandated by HIPAA regulations.

276/277 (*Claim Status Request/Claim Status Response)*: The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following: a) a solicited response to a health care claim status request (276), b) a notification about health care claim(s) status, including front end acknowledgments, or c) a request for additional information about a health care claim(s). The 276 is used only in conjunction with the 277 Health Care Claim Status Response. These are X-12 transactions mandated by HIPAA regulations.

277 (*Unsolicited Claim Status)*: The 277 transaction set can be used to transmit an unsolicited notification about a health care claim status. This is an X-12 transaction mandated by HIPAA regulations.

820 (*Premium Payment)*: The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver. The premium remitter can be: a) an employer-operated internal department or an outside agency which performs payroll processing on behalf of an employer, b) a government agency paying health care premiums, or c) an employer paying group premiums. The premium receiver can be an insurance company, a government agency, or a health care organization. The 820 can be sent from the premium remitter to the premium receiver either directly, through a VAN, or through a financial institution using an ACH (Automated Clearing House) Network to facilitate both the remittance and dollars movement. This is an X-12 transaction mandated by HIPAA regulations.

834 (*Enrollment/Maintenance)*: The 834 is used to transfer enrollment information from the sponsor, the party that ultimately pays for the coverage, benefit, or policy to a payer, the party that pays claims and/or administers the insurance coverage, benefit, or product. This is an X-12 transaction mandated by HIPAA regulations.

835 (*Payment Advice)*: The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. In addition, the 835 can authorize a payee to have a DFI (Depository Financial Institutions) take funds from the payer's account and transfer those funds to the payee's account. This is an X-12 transaction mandated by HIPAA regulations.

837 (*Dental/Professional/ Institutional Claim)*: The 837 is intended to originate with the health care provider or the health care provider's designated agent. The 837 provides all necessary information to allow the designated payer to

at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). This is an X-12 transaction mandated by HIPAA regulations.

997 (*Functional Acknowledgement)*: The Functional Acknowledgement is generated by the receiver of an 837 and is used to notify the sender that the acknowledged transaction has been: a) accepted, b) rejected, c) accepted with errors, or d) partially accepted. This is an X-12 transaction mandated by HIPAA regulations.

A

ABANDONED CALL: A call is considered abandoned if the caller is connected to the system but hangs up before being connected with an agent or informational announcement. Also known as a lost call.

ABR: Automatic Backup and Recovery.

ABD: Aged Blind and Disabled.

ACCEPTED CLAIM: Any claim for services rendered that has passed clerical and machine edits, resulting in a claim that can be accepted for adjudication.

ACCESS CONTROL FACILITY (ACF2): Mainframe security for MMIS. ACF2 for CICS includes security by individual, location, files, and fields.

ACCESS CONTROL FACILITY/MULTIPLE VIRTUAL STORAGE (**ACF/MVS):** A Security Extension to the IBM Multiple Virtual Storage Operating System (MVS OS).

ACCOMMODATION: A hospital room with one or more beds.

ACCOMMODATION CHARGE: A charge billed on inpatient hospital claims for bed, board, and nursing care (revenue codes 100-219).

ACCOUNTS RECEIVABLES (AR, A/R): Money owed to the State by a provider, beneficiary, insurance company, drug manufacturer, etc.

ACCRETION: A process that occurs when a beneficiary is eligible for coverage under both Medicaid and Medicare. Medicaid pays the beneficiary's Medicare premium, thus buying into the Medicare Program.

ACF: Advanced Communications Function.

ACG: Ambulatory Care Grouper.

ACTUAL CHARGE: A charge made by a physician or other supplier of medical services and used in the determination of reasonable charges.

ACTUAL DAMAGES: Damages that can be measured in actual cost.

ACUTE CARE: Medical treatment rendered to individuals whose illnesses or health problems are of a short term or episodic nature. Acute care facilities are those hospitals that serve mainly persons with short term health problems.

AD HOC REQUEST: A request to provide non-production support. This support may be in the form of one-time updates to production files or the creation of specific one-time or as needed output reports.

ADA: Americans with Disabilities Act.

ADA: American Dental Association. The national professional association for dentists.

ADJUDICATE (CLAIM): The adjudication process occurs during claims processing to determine the disposition of a claim (paid or denied). A claim passes through all the edit and audit criteria until it is determined whether all program requirements have been met and whether the claim is to be paid or denied.

ADJUDICATED CLAIM: A claim that has moved from pending status to final disposition, either paid or denied.

ADJUDICATION CYCLE: This cycle refers to the daily or daily/weekly claims processing cycles that are known as the system processing of claims to the point where a decision has been made to pay, deny, or suspend the claim.

ADJUSTMENT: A transaction that changes any information on a claim which has been paid.

ADJUSTMENT PROCESSING: A batch process that sends a file of adjustment request records to the Financial Subsystem for incorporation into the claims processing cycle.

ADJUSTMENT REASON CODES (PRIMARY AND SECONDARY): The adjustment reason codes specify why the initial adjustment took place, whereas the secondary adjustment reason indicates the second adjustment occurrence on a claim. These codes are also known as the primary reason and the secondary adjustment reason.

ADMINISTRATIVE FEE: The operations fees being charged to the DCH on the Contractor monthly invoice.

ADMISSION: The first day on which a patient is furnished inpatient hospital or extended care services by a qualified provider.

ADP: Automated Data Processing.

ADR: Address.

ADVANCE – MANUAL: Advance payment issues as a manual check to be picked up by the provider or sent via Federal Express.

ADVANCE – SYSTEM: Advance payment issues through the system and included in the regular payment cycle.

AFDC: Aid for Families with Dependent Children. This federal program was replaced by Temporary Assistance to Families in Need of Services (TANF).

AICPA: American Institute of Certified Public Accountants.

AID CATEGORY: Program category under which a beneficiary can be eligible for Medicaid.

AID CODE: A designation of the type of benefits for which a Medicaid beneficiary is eligible.

AIMS: Aging Information Management System.

ALERTS: A message related to supervisors or system managers. Alert messages include error messages and emergency warnings.

ALLOWABLE COSTS: The maximum dollar amount assigned for a particular procedure based on various pricing mechanisms. Medicaid reimburses hospitals for certain, but not all, costs. Excluded costs include non-covered services, luxury accommodations, and unnecessary and unreasonable costs.

ALLOWED AMOUNT: Either the amount billed for a medical service or the amount determined payable by the State, whichever is the lesser figure.

ALPHANUMERIC: The use of alphabetic letters mixed with numbers and special characters as in name, address, city, and state.

AMA: American Medical Association. The national professional association of physicians. This organization publishes the highly utilized CPT-4 books.

ANCILLARY CHARGE: A charge used only in institutional claims for any item except hospital and doctor fees (examples include drug, laboratory, and x-ray charges).

ANCILLARY SERVICES: Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided in conjunction with medical or hospital care.

ANSI: American National Standards Institute. In computer programming, ANSI most often denotes the standard versions of C, FORTRAN, COBOL, or other programming languages. ANSI-standard escape sequences control computer screens; whereas ANSI extended character set used in Microsoft's Windows products includes all of the ASCII characters.

APD: Advanced Planning Document. A Federal budget request document that a state must submit to CMS in order to receive enhanced federal funding for Medicaid systems or operations.

APPROVE: A clear, written expression issued by the DCH indicating that Contractor's performance or deliverable is satisfactory under the terms of the Contract.

ARCHIVE: A copy of data on disks, CD-ROM, magnetic tape, etc., for long-term storage and later possible access. Archived files are often compressed to save storage space. (Imaging.)

ASA: Average Speed of Answer.

ASCII: American Standard Code for Information interchange.

The most popular coding method used by small computers for converting letters, numbers, punctuation and control codes into digital form. Once defined, ASCII characters can be recognized and understood by other computers and by communications devices. ASCII represents characters, numbers, punctuation marks or signals in seven on-off bits. Capital "C", for example, is 1000011, while "3" is 0110011. This compatible coding allows all PCs to talk to each other if they use a compatible modem or null modem cable and transmit and receive at the same speed. (Imaging.)

ASO: Administrative Services Organization. An organization contracted to perform functions such as provider and member profiling, case management, disease and care management, nurse call line, enhanced prospective medical review, added fraud and abuse detection, certain eligibility functions and level of care determination for Members where risk based care is not feasible.

ATN: Application Tracking Number. The unique number given to a provider application in the Provider subsystem.

ATR: Accounting Transaction Request. Document used to request Gainwell Technologies create Gross Level AR, Gross Level Payouts, Withholdings, voiding of checks, and Recoupment changes from the DCH.

ATTRIBUTE: Additional fields of information that are required for some call control commands within the telephone system. When you enter a command in a Call Control Table that requires attributes, these fields appear in the table to the right of the command name.

ATTRIBUTE: In graphics, it means the condition a font is in (boldface, italic, underlined, reverse video) is its attribute. In a document retrieval system, an attribute of a file is one of the keys by which the document has been stored and indexed. (Imaging.)

AUDIT: Limitations applied to specific procedures, diagnoses or other data elements after editing and validation of the claim to ensure conformity and consistency of claim payment.

AUTHENTICATION: A query method that ensures that both the sender and receiver of an electronic message are valid and are authorized to transmit and receive messages.

AUTO ASSIGNMENT: An automated process used to make 'intelligent' Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord.

AUTOMATIC RECOUPMENT: Automatic recoupment occurs when an A/R with a credit balance has recoupments applied to it by adjustments or new-day claims. Money is recouped only through the payment process, which is automatic, and cannot be posted online with a refund.

AVAYA AURA CONTACT CENTER (AAC): Utilizes Avaya Aura Agent Desktop (AAAD) Version 7.03 with AACC telephone system provides information and management tools to help monitor and analyze the performance of the call center operation.

AVRS: Automated Voice Response System. (See IVR for definition.)

B

BACKUP: Duplicate copy of data placed in a separate, safe place - electronic storage, on a tape, on a disk, in a vault - to guard against total loss in the event the original data somehow becomes inaccessible. Generally for short-term safety. Contrast with archive, which is a filed-away record of data meant to be maintained a long time, in the event of future reference. (Imaging.)

BATCH: A set of claims. Paper claims are batched by invoice type, e.g., UB-04, HCFA-1500, pharmacy, adjustments, etc. The number of claims in a paper batch may vary from 1 to 99. Electronic batches have no claim ceiling, but must contain at least 25 claims. Claims are batched to control the quality and quantity of claims entered into the system. Batching supports the assignment of a unique set of numbers to a specific set of claims. There are specific batch number ranges for certain batch types: EMC, adjustments, credits, POS transactions, etc.

BATCH CYCLE: Batch cycles are scheduled and managed by the Autosys job scheduling software. Processing from all the subsystems and claim adjudication is done at this time. Many edits and parameters are used for a batch cycle.

BATCH PROCESSING: One of the non-interactive computer processes used in the MMIS. In batch processing, the user gives the computer a "batch" of information and the computer then processes it as a whole. Batch processing contrasts with interactive processing, in which the user communicates with the computer by means of a workstation while the program is running.

BATCH REQUEST: A batch request does not require immediate processing. The requester does not wait for the request to be completed, and it does not receive a success or failure response back from the unit storage. (Imaging.)

BBA: Balanced Budget Act of 1997. Federal legislation enacted in 1997 that gave beneficiaries certain rights related to Managed Care enrollment and disenrollment. Most significant changes in the Medicaid/Medicare Program since their inception. Provides for state option to use Managed Care. Provides that an MMIS must be compatible with Medicare claims processing and must, after January 1, 1999, transmit data in a format consistent with the Medicaid Statistical Information System (MSIS).

BIAR: Business Intelligence and Analytical Reporting.

BENCHMARK: A level of care set as a goal to be attained. For example, competitive benchmarks are comparisons with the best external competitors in the field. The State Children's Health Insurance Program benefit package includes a benchmark

package that is used to compare other benefit packages' value and comprehensiveness.

BENDEX: Beneficiary and Earnings Data Exchange System. A file containing data from the federal government regarding all persons receiving benefits from SSA and the Veterans Administration.

BENEFICIARY IDENTIFICATION CODE (BIC): This code specifies the type of beneficiary for cash payment programs and identifies the type of relationship between the individual and primary beneficiary when the individual is qualified under another's account. The code is equated to a common BIC.

BENEFIT PLAN: A group of covered services (benefits) that are granted to a beneficiary who is deemed eligible for the program the benefit plan represents.

BENEFITS: The process whereby a State pays for medical services rendered to Medicaid-eligible beneficiaries.

BILLED AMOUNT: The billed amount is the dollar figure submitted by a provider for medical services rendered.

BIN: Bank Identification Number.

BITMAP: Representation of characters or graphics by individual pixels, or points of light, dark or color, arranged in row (horizontal) and column (vertical) order. Each pixel is represented by either one bit (simple black and white) or up to 32 bits (fancy high definition color). (Imaging.)

BRIGHTNESS: The balance of light and dark shades in an image. Contrast with contrast. (Imaging.)

BROKER: The contracted Vendor which is responsible for the Non-Emergency Transportation (NET) Program. (See definition of NET.)

BRS: Benefits Recovery Services. The Unit at the DCH responsible for addressing accounts receivables, liens, recoupments, refunds, etc.

BULLETINS: Directives mailed, e-mailed, uploaded to the Web Portal to Georgia Medical Assistance Program providers containing information on policy, billing procedures, benefits and limitations, etc.

BUNDLED CHARGES: Charges that are combined together or represent a flat rate such as in capitated reimbursed where there would be a specified fee for a service. In an example of a surgery procedure, the bundled charges would include supplies, surgery charges, anesthesia charges, recovery, etc. In contrast, unbundled charges would be separate charges for each entity.

BUSINESS ASSOCIATES: Person or organization that performs a treatment, payment, or health care operations function or activity on behalf of a covered entity.

BUSINESS DAY: Any day the State is open for normal business operations.

BUSINESS PRACTICE MANUAL (BPM): The Fiscal Agent internal user manuals.

BUY-IN: Procedure whereby states pay a monthly premium to the Social Security Administration on behalf of Medicaid beneficiaries, enrolling them in Medicare Title XVIII Part A and/or Part B program.

BYTE: Common unit of computer storage. A byte is eight bits of information, one of which may be a parity bit. Generally, eight bits equals one character. Also called 'octet'. (Imaging.)

C

CACHE: (Pronounced "cash") Small portion of high-speed memory used for temporary storage of frequently used data. Reduces the time it would take to access that data, since it no longer has to be retrieved from the disk. (Imaging.)

CARRIER: A carrier refers to a private insurance company.

CASE NUMBER: The number assigned to each Medicaid case opened by DFCS.

CATEGORICALLY NEEDY: The term that identifies those aged, blind or disabled individuals or families who meet Medicaid eligibility criteria and who meet the financial limitation requirements for TANF, SSI or optional State financial support.

CCB: Change Control Board, a formally constituted group of the DCH staff responsible for approving or rejecting changes to the source code, run-time files, documentation, configuration files and installation scripts that comprise the Proprietary and Non-Proprietary Software.

CCN: Cash Control Number. This is the unique number assigned to a Cash Receipt.

CCP: Change Control Process. This is the process used to review, escalate, and dispose (approved or denied) any necessary changes made to project requirements.

CERTIFICATION: This review is conducted in response to a State's request for 75 percent Federal Financial Participation (FFP), to ensure that all legal and operational requirements are met by the MMIS system and its components.

CERTIFICATION DATE: An effective date specified in a written approval notice from CMS to the State when 75 percent FFP is authorized for the administrative costs of an MMIS.

CFR: Code of Federal Regulations. A codification of the general and permanent rules published in the federal register by the Executive departments and agencies of the federal government.

CHANGE CONTROL: The exercise of authority over changes to configuration items, including impact analysis, prioritizing, granting access, signing out, approving or rejecting, capturing change contents, and adding.

CHARACTER RECOGNITION: The ability of a machine to read human-readable text. (Imaging.)

CHARACTER VALIDATION: As each character is entered by the data capture team member, its validity is checked and the character is corrected, if necessary. (Imaging.)

CGI: Common Gateway Interface. One of the most common ways to add programs or scripting languages that execute on the server to your Web-based applications.

CIS: Children's Intervention Services.

CISS: Children's Intervention School Services.

CLAIM: A request for payment filed with the fiscal agent, on a form prescribed by the DCH and the fiscal agent, by a certified Medicaid provider for Medicaid-covered medical and medically related services rendered on behalf of an eligible Medicaid beneficiary.

CLAIM TYPE: The classification of a claim by origin or type of service provided to a beneficiary.

CLAIM HISTORY: All claims processed in the MMIS are kept available in the system and are referred to as being "in history."

CLEAN CLAIM: See "Accepted Claim."

CLIA: Clinical Laboratory Improvement Amendments.

CMMI: Capability Maturity Model Integration.

CMO: Care Management Organization.

CMS: Centers for Medicare and Medicaid Services. The federal agency (formerly known as HCFA) responsible for the administration of the Medicaid, Medicare, and other health care programs.

CMS 1500: The claim form used by the DCH to file for services performed by most practitioners.

CO: Change Order. The documentation of a modification to the transfer system. A change order is not a modification of a requirement; it is the modification of the base system to meet an existing requirement.

COB: Coordination of Benefits.

COE: Category of Eligibility or Aid Category.

COINSURANCE: An arrangement by which an insurance plan, Medicare, Medicaid or other third party share the cost of medical expenses.

COMMUNICATION PROTOCOL: Establishes the communication parameters between two computers. Includes baud rate, type of transmission, and parity setting.

COMMUNICATIONS: The means of electronically linking two computers to exchange information in EDI.

COMMUNICATION SOFTWARE: Software necessary to add appropriate protocols to the EDI documents in preparation for transmission over a telecommunications network.

COMPANION DOCUMENTS: A guide of Georgia specific information to be used in coordination with the Implementation Guide for X12 and NCPDP formatting.

COMPLAINT: A relatively minor verbal or written expression of concern about a situation that can be resolved on an informal basis.

COMPLIANCE CHECKING: A validation check to ensure that a transmission contains the minimum mandatory information required by the EDI standard.

CONTACT: A record of an interaction between a customer (provider or member) and a system user.

CONTRACT: The written, signed agreement resulting from this RFP.

CONTRACT MANAGER: Person or entity designated by the DCH as the chief point of contact for communications with the DCH for the Operations Phase. Provides project direction and monitors the activities of the contract.

COS: Category of Service. This would relate to the provider contract in Gainwell Technologies.

COST AVOIDANCE: A claim may be denied when coverage exists and there is no indication that the carrier has been billed (cost avoided).

COST SHARE: The amount that a member receiving services under CCSP or an HCBS waiver may be required to pay toward the cost of reimbursement for services received.

COTS: Commercial Off-the-Shelf Software.

CPT: Common Procedural Terminology. A unique coding structure scheme for all medical procedures approved by the American Medical Association.

CROSSOVER CLAIM: A claim for services rendered to a member eligible for benefits under both Medicaid and Medicare programs. Medicare benefits must be processed prior to Medicaid benefits.

CROSS WALK: A table used to map one code to another code.

CSR: Customer Service Request.

CTMS: Contact Tracking Management Solution. This ancillary application provides a means of access and storage for all information associated with a customer service contact. All contact information is associated with an assigned CTN. This information includes contact type, demographic information, questions, resolutions, and contact reasons. Gainwell Technologies and the DCH staff enter information for each contact through online windows. Search windows allow users to sort and access contacts based on a variety of criteria. Reports are available based on open dates, status, specialists IDs and department.

Example:

Item: Written Correspondence

Details of the written correspondence are stored within CTMS

Actual process of where the written correspondence goes is Workflow

CTN: Contact Tracking Number. A unique number used in CTMS.

CUSTOMARY CHARGE: A dollar amount that represents the median charge for a given service by an individual physician or supplier.

CUSTOMIZATION: Process of building or modifying an instrumentality in accordance with the State of Georgia, Department of Community Health's specification.

CVO: Credentialing Verification that is responsible for primary source verification of provider education, training, practice liability according to National Credentialing Quality Association (NCQA) guidelines which is their certifying body.

CYCLE: A single event that is repeated, for example, in a carrier frequency, one cycle is one complete wave. Or, a set of events that is repeated, for example, in a polling system, all of the attached terminals are tested in one cycle.

D

DATA: Individual facts, statistics or items of information.

DATABASE (DB): Data that has been organized and structured in a disciplined fashion, so that access to information of interest is as quick as possible. Database management programs form the foundation for most document storage indexing systems. (Imaging.)

DATABASE ADMINISTRATOR (DBA): The person responsible for maintaining the database system**:** managing data, designing database objects, database performance and data recovery and integrity at a physical level. This person is not an applications programmer.

DATABASE TABLE: A collection of similar records in a database within the telephone system. The Call Center software uses database tables to store all types of user-entered information. For example, the User table contains one record for each user in the system. The Agent Group table defines each agent group and sets options for each. All tables in the system database are accessed through the Database command on the Call Center main menu.

DATA CAPTURE: Entering data into the computer, which includes keyboard entry, scanning and voice recognition. When transactions are entered after the fact (batch data entry), they are just stacks of source documents to the keyboard operator. Deciphering poor handwriting from a source document is a judgment call that is often error prone. Online data capture team members, in which the team member

takes information in person or by phone, entails interaction and involvement with the transaction and less chance for error.

DB2: Database 2.

DCH: State of Georgia, Department of Community Health.

DCN: Document Control Number. A unique number assigned to each document as it is imaged.

DDI: Design, development, and implementation.

DED: Data Element Dictionary. Describes the fields (data elements) within a database.

DEDUCTIBLE: The amount of expense a member must pay before Medicare or another third party begins payment for covered services.

DEERS: Defense Enrollment and Eligibility Reporting System. A system that contains eligibility information on CHAMPUS, the insurance company for military dependents.

DELEGATION: Providers that have their own NCQA certified organization that credential their providers according to NCQA guidelines. These providers must provide a completed delegation form and attach to their initial enrollment application.

DELIMITER: A special character used to separate fields of data. The three used in an EDI file are the segment delimiter, the element delimiter, and the sub-element delimiter.

DENIED CLAIM: A claim for which no payment is made to the provider because the claim is for non-covered services, an ineligible provider or member, is a duplicate of another transaction, contains invalid information, or is missing required information.

DENTAL CLAIM: A claim filed for payment of dental services. A claim is filed: (1) for dental screening for children, (2) for one or more services given on a single day, or (3) upon completion of service for a condition. The claim is filed on the American Dental Association claim form or HIPAA-compliant electronic claim format.

DENTAL SERVICES: Any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. These services may include treatment of teeth and associated structures of the oral cavity and treatment of disease, injury, or impairment that may affect the oral or general health of the individual. Services are subject to the limitations established under the Georgia Medicaid program.

DEPARTMENT ID: Field that categorizes a transaction as Aged Blind and Disabled (ABD), Low Income Medicaid (LIM), or PeachCare (PCK). Dept. ID for claims is derived from the COE and is drop down field for gross level payouts and receivables. Also uses COS to determine final value on the accounting interface.

DESKTOP IMAGING SYSTEM: An imaging system with a single workstation (often a microcomputer) meant to be used by only one person at a time. (Imaging.)

DFCS: State of Georgia, Department of Human Services Division of Family and Children Services.

DHHS: United States Department of Health and Human Services.

DHS: State of Georgia, The Department of Human Services.

DIAGNOSIS CODE (DIAG, DX): The medical classification of a disease or condition according to ICD-9-CM or HCPCS. A numeric code that identifies the patient's condition as determined by the provider of the performed service.

DISPOSITION (CLAIMS): The actual status of a claim. The result of processing a claim is the assignment of a status or disposition. The disposition of a claim is determined by the Exception Control File.

DISPOSITION (FINANCIAL): The posting of a receipt against a payee gross level AR or claim AR, gross level of the receipt, or refunding of the receipt.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM: A federal program that works to increase health care access for the poor. Hospitals that treat a disproportionate number of Medicaid and other indigent patients qualify for DSH payments through the Medicaid program based on the hospitals' estimated uncompensated cost of services to the uninsured.

DME: Durable Medical Equipment.

DMO: Disease Management Organization.

DOAS: Department of Administrative Services, State of Georgia.

DOB: Date of Birth.

DOCUMENT: Structured file. In ASC X12 usage, a document is synonymous with a transaction set.

DOCUMENT IMAGES: A computerized representation of a picture or graphic. (Imaging.)

DOCUMENT RETRIEVAL: The ability to search for, select and display a document or its facsimile from storage. (Imaging.)

DR: Disaster Recovery. Facilities, plans, tests, etc. for the recovery of the MMIS from a total loss.

DRA: Deficit Reduction Act.

DRG: Diagnosis-Related Group. DRGs are the basis for one type of hospital reimbursement. A hospital specific fee is calculated for each diagnosis group for each hospital. Factors of age, sex, length of stay data, and historical costs for each hospital are taken into consideration in calculating the reimbursement amount. Usually, mental institutions and pediatric hospitals are excluded from DRG reimbursement due to the abnormal length of stay experienced by most patients.

DSD: Detailed System Design. Document created by the Fiscal Agent as a detailed guide to developing a new system or subsystem.

DSM: The Georgia Disease State Management Enhanced Care program administered by contracted Disease Management Organizations.

DSM III: Diagnostic and Statistical Manual for Mental Disorders, Third Edition, Revised. A publication of the American Psychiatric Association establishing a coding system for mental diagnoses.

DSS: Decision Support System.

DUPLICATE CLAIM: A claim that is either a total or partial duplicate of services previously paid. It is detected by comparing a new claim to processed claims history files.

DUPLICATE PAYMENT: A payment to a provider for services provided to a beneficiary resulting from the processing of a duplicate or near-duplicate claim by the contractor.

DUR: Drug Utilization Review.

E

EDI: Electronic Data interChange. Standard format for exchanging business data. The standard is ANSI x12, which was developed by the data interchange standards association (DISA). ANSI x12 is either closely coordinated with or is being merged with an international standard, EDIFACT. Standards for EDI include: ANSI for claims, eligibility, enrollment, EBT, and remittance. CCIT for others. NCPDP for pharmacy, HEDIS for managed care.

EDIT: As applied to MMIS, an edit is a set of parameters against which a claim transaction is "edited." These edits can stop payment and/or generate reports. The verification and validation of claims data for detection of errors or potential error situations. Logic placed in the MMIS programming to cause claims that have specific errors to be placed in a suspend or deny mode due to not having successfully passed these edits.

EDMS: Electronic Document Management System.

EFT: Electronic Funds Transfer An electronic deposit system for provider remittance amounts, and the process of authorizing a computer system to transfer funds between accounts.

EHR: Electronic Health Records.

ELIGIBLE: Person who has been certified by the appropriate agency as meeting the criteria to qualify for Medicaid.

ELIGIBILITY FILE: A file that contains pertinent data for each Medicaid eligible individual enrolled in the Medicaid Program.

ENCOUNTER DATA: Information submitted to the MMIS by HMOs, PCP/CMs or other managed care organizations to describe service utilization by Medicaid beneficiaries.

ENCOUNTER RATE: A term used when Federally Qualified Health Centers (FQHC) and rural health clinic (RHC) providers bill and receive a rate (encounter rate) as opposed to a FFS reimbursement rate.

END USER: The ultimate consumer of an interChange product, especially the one for whom the product has been designed.

ENHANCE: Improve quality of software, hardware or other equipment.

ENROLLMENT BROKER: Contractor tasked with providing each Member and Potential Member with information about each CMO plan and assisting the Member in selecting a CMO plan and primary care provider that meets his/her family and individual health needs. This function will be included in the MMIS scope of work for this contract.

ENVELOPE: The combination of a header, trailer, and sometimes other control segments, that define the start and end of an individual EDI message.

EOB: Explanation of Benefits. A notice issued to the provider of Medicaid-covered services that explains the payment or non-payment of a specific claim processed for a member.

EOMB: Explanation of Medical Benefits. A notice issued to members selected at random listing all of the Medicaid services the member received the prior month. It instructs the case head to inform the DCH if any services listed were not received and of any other problems.

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment. This term is used interchangeably with Health Check for the purposes of this RFP.

ESC: Error Status Code. Edit or audit assigned to indicate the error found on the suspended claim.

EXCEPTION: The phrase "posts an exception" is commonly used when discussing claims processing to indicate there is data on the claim that fails an edit; therefore, an exception is posted to the claim.

EXP: Expenditures. The issuance of checks, disbursement of cash, or electronic transfer of funds as reported by the state.

F

FACS CODING: Fund Source, FFP, and SCOA.

FBR: Federal Benefit Rate. The income limit used by SSA in determining SSI eligibility.

FEDERAL CERTIFICATION: The written acknowledgement from CMS that the operational MMIS meets the legal and operational requirements necessary for a percentage of Federal Financial Participation (FFP).

FEIN: Federal Employer Identification Number. Number assigned to a business entity for tax purposes. This number might be of value in identifying all the businesses owned by a corporation.

FFP: Federal Financial Participation. A percentage of State expenditures to be reimbursed by the federal government for medical assistance and for the administrative costs of the Medicaid Program. Federal Participation Percent which determines the funding split between state and federal funds. The period to use is based on Date of Payment.

FFS: Fee-for-service.

FIELD: An on-screen area used for entering specific information, such as a name or extension number, within the telephone system. A field prompt identifies the type of information that belongs in each field.

FIELD LEVEL PARAMETERS: Define each field on the claim form as being data or mark sense; establish X and Y coordinates where the date is found; set the field level readability requirements; determine whether the field is alpha, numeric or alphanumeric; and define the data validity editing to which the field will be subjected. (Imaging.)

FIELD VALIDATION: As each field is completed by the data entry operator, its validity is checked and the field is corrected, if necessary. (Imaging.)

FILE MAINTENANCE: The periodic updating of master files. For example, adding or deleting employees and customers, making address changes and changing product prices. It does not refer to daily transaction processing and batch processing.

FIREWALL: Security protection for a Web site (see proxy server), LAN, and Intranet. May check incoming and outgoing messages.

FIRM FIXED PRICE: A single price established by the awarding of this contract that is not subject to change or negotiation over the life of the contract.

FISCAL AGENT (FA): A contractor that processes for payment and adjudication, audits provider claims for payment, and performs other related functions, as required, as an agent of the DCH.

FISCAL YEAR (FY): Federal - October 1 through September 30; State of Georgia - July 1 through June 30.

FLAT FILE: A database consisting of one table. It is a stand-alone data file that does not have any predefined linkages or pointers to locations of data in other files. This is the type of file used in a relational database; however, the term is often used to refer to a type of file that has no relational capability, which is exactly the opposite.

FORM LEVEL PARAMETERS: Establish the page size, ICN format, scanner control, image boost, dot matrix filter used, and acceptable readability. (Imaging.)

FPL: Federal Poverty Level. The minimum income required to support basic living costs for a family. The FPL is established yearly by the federal government and is based on the number of persons in a family.

FTE: Full Time Equivalent.

FTP: File Transfer Protocol. A method of transferring files between heterogeneous computing platforms. Since most large scale computing systems interface between mainframes, mini, PCs, and the Internet, a method is needed to transfer data between these different platforms. (See TCP/IP.)

FULL REFUND: Receipt received from a provider for the full amount of the original claim that was paid.

FUNCTIONAL ACKNOWLEDGEMENT: An EDI message that is sent in response to the receipt of an EDI message or packet of messages to notify the sender of the original message that it was received. It acknowledges only the receipt of the message or message packet, and does not imply agreement with or understanding of its content.

FUND SOURCE: The accounting interface codes used for federal and state funding based on the FFP determinations.

G

GAAP: Generally Accepted Accounting Principles.

GAAS: Generally Accepted Auditing Standards.

GAO: Federal Government Accountability Office.

GATEWAY: The interconnection between public or private networks that allow the transmission of documents in X12 format across multiple networks. Also called interconnect.

GB: Gigabyte.

GHF: Georgia Families. A Georgia program developed to deliver health care services to members of Medicaid and PeachCare for Kids®. The program is a partnership between the Department of Community Health and private care management organizations (CMOs).

GIS: Geographic Information System.

GMCF: Georgia Medical Care Foundation.

GO-LIVE DATE: Date on which application can be moved to a live environment after all testing has been successfully completed and written approval has been received from the DCH.

GROSS LEVEL AR: Accounts Receivable transaction created on a payee that is not system generated based on net negative claim activity.

GROSS LEVEL PAYOUT: Payment made outside of the claims adjudication process and typically not linked to specific claims. Gainwell Technologies refers to as Expenditures.

GROSS LEVEL RECEIPT: Posting of a receipt against a payee number not linked to any AR or claim activity. Reduces 1099 balance but does not affect future payments.

GTA: Georgia Technology Authority.

GUI: Graphical User Interface. A "windows" based computer interface that allows for consistency of this application with other applications used by the operators. The device drivers associated with these GUIs optimize the painting of snippets and the rendering of fonts to take full advantage of the high-performance graphic cards installed in PCs.

H

HCBS: Home and Community-Based Services. HCBS includes waivered services for the elderly, disabled, mentally retarded/developmentally disabled, and physically handicapped.

HCPCS: HCFA Common Procedure Coding System. A coding system designed by HCFA (now CMS) that describes the physician and non-physician patient services covered by Medicaid and Medicare programs. It is used primarily to report reimbursable services rendered to patients.

HEALTH CHECK: Screening and immunization services, case management and continuing care services for children under 21 years of age, which are provided by a Medicaid provider approved as a screener. The services are reimbursed on a fee-for-service basis for private providers and on an encounter rate based on costs for clinic providers. EPSDT is used interchangeably with Health Check for the purposes of this RFP.

HEALTH CHECK CLAIM: A claim filed for payment of EPSDT Services. A claim is filed for screening or immunization services. The claim is filed on the CMS-1500 form.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law that includes requirements to protect the privacy of individually identifying health information in any format, including written or printed, oral and electronic, to protect the security of individually identifying health information in electronic format, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

HIPP: Health Insurance Premium Payment. A program where Medicaid-eligible beneficiaries may receive insurance premium assistance using Medicaid funds when it is determined cost-effective to purchase group health insurance.

HISTORY ONLY: The linking of a refund or a voided check to a claim that does not adjust the claim in such a way that it would affect a subsequent provider payment.

HOME HEALTH CLAIM: A claim filed for payment of Home Health Services. A claim is filed: (1) for one or more services given on the same date; (2) upon completion of services for a treatment period; or (3) at the end of a calendar month. The claim is filed on a CMS-1500 claim form.

HOME HEALTH SERVICES: These are provided in a home setting by a licensed home health agency that participates in the Medicaid Program. Services include but are not limited to skilled nursing, home heath aid, physical therapy, occupational therapy, and speech therapy. Reimbursement for covered services is based on reasonable cost as determined by cost reports and applicable costs of supplies and equipment.

HOST: Computer in which an application or database resides or to which a user is connected. Sometimes used generically as synonym for computer. (Imaging.)

HOT KEY: A term used to define the key used to request an imaged document to be retrieved. (Imaging.)

HYPERTEXT MARKUP LANGUAGE (HTML): Programming language used to develop and maintain web pages on the Internet.

HYPERTEXT TRANSFER PROTOCOL SECURE (HTTPS): Protocol to provide encrypted transmission of data between Web browsers and Web servers.

I

ICD-9-CM: International Classification of Diseases, 9th Revision Clinical Modification.

ICD-10-CM: International Classification of Diseases, 10th Revision Clinical Modification.

ICF/MR: Intermediate Care Facility for the Mentally Retarded.

ICF/MR CLAIM: A claim filed for payment of ICF/MR Services. A claim may be filed: (1) at the end of a calendar month; or (2) for the total period of confinement, if less than one month. The claim is currently filed on a UB-92 form.

ICF/MR SERVICES: Services provided in a licensed ICF/MR facility that participates in the Medicaid Program. The level of care is less than that received in a SNF. The per diem reimbursement is determined by cost report data.

ICN: Internal Control Number. Each claim is imprinted with an ICN in a sequential numbering order, beginning with the initial ICN keyed in the system by the scanner operator. The ICN is printed across the top of the claim and is also written out to the OCR output record. The imaging system captures the ICN for indexing of the claim images and compiles a file containing all ICNs used to automatically update the control range of valid ICNs within the MMIS. A unique 13-digit identification number assigned to every GAMMIS claim in order to distinguish it from all other claims

received by the system. The ICN consists of: two-byte Region, which represents claim media and claim type; a five-byte Date of Receipt, which consists of the YY – year and JJJ – Julian; and a six-byte Sequence number.

ICWP: Independent Care Waiver Program.

IMAGE: The computerized representation of a picture or graphic. (Imaging.)

IMAGE CAPTURE: The Kodak 990D scanner transportation carries the paper claim past the scanning array, which captures an image of the claim. This image is simultaneously sent to both the OCR subsystem and the CIRRUS imaging system.

IMAGING: A method of electronically capturing a representation of a form, whether it is a claim or other piece of correspondence, to allow rapid retrieval and processing of the source document copy.

IMPLEMENTATION GUIDE: A publication that identifies and defines the EDI messages used in a particular industry or application. The document indicates how the information in those messages should be presented on a segment by segment, and data element by data element basis, as well as identifying which segments and data elements are needed, which ones need not be used, and what code values will be expected in the application of that particular message.

INCENTIVES: A monetary or non-monetary motivator that is incorporated or result from the Contractor performance measures of the contract. These incentives influence the Contractor toward accomplishing the desired contractual outcomes.

INDIGENT CARE TRUST FUND (ICTF): The ICTF represents the largest component of DSH payments distributed through Georgia Medicaid. To participate in ICTF, a hospital must be a DSH provider. With ICTF funding, uninsured people who do not qualify for Medicaid may receive health care from participating hospitals.

INDUSTRY SPECIFIC: In EDI, it refers to the ability of an EDI Standard to be used by only one industry.

INITIATING SPECIALISTS ID: The ID of the specialists who initiated the claim adjustment online. The Financial system tracks this specialists ID as well as subsequent specialists who work on this adjustment by capturing and storing these IDs.

INPATIENT CARE: Care provided to a patient while institutionalized in an acute care facility.

INPATIENT HOSPITAL CLAIM: A claim filed for payment of Inpatient Hospital Services. A Claim may be filed: (1) for the total period of hospitalization; or (2) at some point during the hospitalization. The claim is currently filed on a UB-04 form.

INPATIENT HOSPITAL SERVICES: Services provided in a licensed hospital which participates in the Medicaid Program. Inpatient services are reimbursed based on a hybrid-DRG prospective payment system. The majority of cases are reimbursed using a DRG per case rate. Remaining cases are paid based on a hospital-specific cost-to-charge ratio (CCR) system.

INQUIRY MODE: An window mode where the user is viewing data as the result of an inquiry rather than having accessed the specific window in order to add, change or delete data from certain financial records and/or claims. Inquiry Mode allows flow between the various parts of the system but does not allow changes to the data being viewed.

INSTITUTIONAL CARE: Medical care provided in a hospital or nursing home setting.

INTERNET PROTOCOL (IP): Works like the postal system. There is no direct connection – just the packet address to send messages to, and the address for returned messages.

IRS: Internal Revenue Service.

ISDM: Information Systems Development Methodology.

ISP: Internet Service Provider. Commercial provider of Internet services; e.g., AOL, Bellsouth, Comcast, and so on. To use the Internet a user must have a commercial ISP that maintains a computer system through which the user accesses the Internet.

ITF: Integrated Test Facility.

IVRS: Interactive Voice Response System. This is the machine and the application that enable users to access Georgia Medical Assistance Program information by using a touch-tone telephone.

IV&V: Independent Verification and Validation. The verification and validation of the design, development, and implementation (DDI) of the MMIS by an organization that is both technically and managerially separate from the organization responsible for developing the product.

J

JAD: Joint Application Design. Facilitated sessions between the Contractor and the DCH users to ensure that the Contractor understands the State role, the Contractor role and the system requirements for each business area.

JCL: Job Control Language.

JOB QUEUE: A list of procedures in progress and procedures waiting to be run within the telephone system.

JOIN: A join defines explicit relationships between tables in a relational database. All other relationships are strictly implied. These joins enable users to relate the data in one table to data in another table in the same database so the user can query data from more than one table at a time. Tables are joined through columns.

JOIN PATHS: Join paths are the actual joins between tables in a relational database.

JOINT APPLICATION DESIGN (JAD): The process where the system user and designer meet together to define the application. Generally, requirements are reviewed, validated, and clarified.

JULIAN DATE: The representation of month and day by a consecutive number starting with January 1. For example, February 1 is Julian 032. Dates are converted into Julian dates for calculation.

K

KEY: Keys are indexed columns in tables, often used to join tables. Keys uniquely identify each record, or row, in a table. Examples would be Customer-ID or provider number.

L

LAN: Local Area Network. A communications network that serves users within a confined geographical area. It is made up of servers, workstations, a network operating system and a communications link. Servers are high-speed machines that hold programs and data shared by all network users. The workstations, or clients, are the users' personal computers, which perform stand-alone processing and access the network servers as required.

LAW: Refers to constitutional provisions, statutes, common law, case law, administrative rules, regulations, and ordinances of the United States of America or the State of Georgia.

LIM: Low Income Medicaid.

LIEN/WITHHOLD: The taking of money from payment activity that does not reduce the payee 1099 balance.

LINE ITEM: A term used in reference to a level of detail on a claim. Line item details are services billed using a procedure code, a quantity, and a date of service for a specific fee. Claims may have multiple line items or detail lines.

LIQUIDATED DAMAGES: Payment made to the State for Contractor performance failures for which the actual cost or damage to the State cannot be determined or measured at the time of the failure.

LOC: Level of Care.

Long Term Care (LTC): Long-term care is the personal care and other related services provided on an extended basis to people who are clinically complex and may suffer from multiple acute or chronic conditions.

LTCF: Long-Term Care Facility.

LEVERAGED TECHNOLOGY GROUP (LTG): The SE support group which processes the FDB DUR criteria update files, and passes the massaged updates on to the interChange systems.

M

MAO: Medical Assistance Only. An eligibility group that receives assistance for medical services but does not receive money payment assistance.

MANUAL CHECKS: Checks written outside the automated check writing cycle.

MANUAL CLAIMS: Claims processed outside the automated claims cycle.

MANUAL RECOUPMENTS: Manual recoupments are non-claim-specific recoupments (financial reimbursements). These accounts receivable are manually set up by the State of Kansas to recoup money from providers.

MAPPING: The act of determining what pieces of information in the company's database should be placed into each data element of an EDI message or transaction set, or in reverse, what data elements of an EDI message or transaction set should be placed into the company's database.

MARS: Management and Administrative Reporting Subsystem. The MMIS subsystem that produces the management data required for financial, benefit, provider and member reporting.

MARTA: Metropolitan Atlanta Rapid Transit Authority.

MASS ADJUSTMENTS: The systematic adjustment of more than one claim at the same time for the same reason. Multiple adjustments entered at one time. Mass adjustments are requested on line and they are particularly useful when it is necessary to reprocess hundreds or thousands of claims. Mass adjustment requests are submitted for a specific population of claims. In other words, claims that have something in common. They may be all of the drug claims processed after a certain date, they may be a subset of claims for a specific provider, or they may be all of the claims processed for a specific beneficiary. The criterion for claims selection is highly variable.

MATERIAL COMPONENT(S) OF THE SYSTEM: A constituent element of the Medicaid Management Information System, or any of its ancillary systems, which is necessary for the system to function in accordance with the terms and requirements described in the RFP, the Contractor’s proposal and this Contract.

MEDICAID: The joint federal and State medical assistance program that is described in Title XIX of the Social Security Act.

MEDICAL REVIEW (MR): Analysis of Medicaid claims to ensure that the service was necessary and appropriate.

MEDICARE: The federal medical assistance program that is described in Title XVIII of the Social Security Act.

MEDICARE CROSSOVER CLAIM: See "Crossover Claim."

MEDICARE PART A: Part A of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for hospital and hospital-related services. The formal designation is "Hospital Insurance Benefits for the Aged".

MEDICARE PART B: Part B of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for physician's services. The formal designation is "Supplementary Medical Insurance Benefits for the Aged".

MEMBER: An individual eligible for medical assistance in accordance with a State's Medicaid Program or SCHIP Program (PeachCare for Kids®) and who has been certified as eligible by the appropriate agency and has received services.

MITA: Medicaid Information Technology Architecture.

MMIS: Medicaid Management Information System.

MSIS: Medicaid Statistical Information System commonly referred to as the automated submission of the CMS-2082 data to CMS.

MTD: Month to Date.

N

NAT: Nurse Aid Training.

NDM: Network Data Mover. A communications protocol for transferring data from one mainframe computer to another.

NET: Non-Emergency Transportation. NET Medicaid Program which through contractual agreements with brokers ensures the availability of non-emergency transportation to Medicaid-eligible persons who do not otherwise have access to transportation to medically necessary care.

NEW DAY CLAIM: Any claim, with or without attachments, received for payment consideration on that current business day. A claim is only considered "new day" on the initial date of receipt. Once the current day has passed, all unprocessed new day claims become part of the shelf inventory, which consists of all claims waiting to be processed.

NON-PROPRIETARY SOFTWARE: Any software or associated documentation that is not Proprietary Software.

NPF: National Provider File.

NPI: National Provider Identifier as required by HIPAA.

NPP: Notice of Privacy Practices, as required by HIPAA.

NPS: National Provider System. An application system through which users have the capability to assign NPIs to providers and to access/update provider identification data. A voluntary federal and state joint venture to support CMS' Medicare Transaction System and to simplify program operations and provider transactions across programs. It will replace the existing Medicare Physician Identification and Eligibility System (MPIES) that currently issues the Medicare Unique Physician Identification Number (UPIN). Subsequently, new physicians would obtain a National Provider Identifier (NPI) rather than a UPIN number.

NSP: Network Service Provider. A company that maintains a network and offers its services and capabilities to others for a fee.

NTP: Non-Traditional Provider. Providers associated with a Georgia Families Managed Care Organization that are registered in the MMIS for informational reasons. The providers are not entitled to participate in the Georgia Medicaid/PeachCare for Kids® fee-for-service program.

NURSING FACILITY SERVICES: Services provided in a facility that is licensed and regulated to provide nursing care services or intermediate care services for the mentally retarded and that participates in the Medicaid program. The per diem reimbursement is determined by cost report data, the level of care provided by the facility, and the case mix average score derived through the submission of resident assessments received from the nursing facilities electronically in a separate subsystem.

O

ONLINE: The use of a computer terminal to display computer data interactively. Available for immediate use. If your data is on disk attached to your computer, the data is online. If it is on a disk in your desk drawer, it is offline. Systems are designed as either online or batch. Online means terminals are connected to a central computer, and batch means entering batches of transactions on a second or third shift. Other terms, such as real-time and transaction processing evolved from online processing.

OPERATIONAL PHASE: The period of the contract that pertains to the day-to-day maintenance and operations of the MMIS and other functions as required.

OUTPATIENT CARE: Care provided to a patient in a non-institutionalized setting, such as a hospital outpatient clinic, emergency room, or other hospital based facility where room and board has not been provided.

OUTPATIENT HOSPITAL CLAIM: A claim filed for payment of Outpatient Hospital Services. A claim is filed: (1) for one or more services given on the same date; (2) upon completion of services for a treatment period; or (3) at the end of a calendar month. The claim is currently filed on UB-04 form.

OUTPATIENT HOSPITAL SERVICES: Services provided in a hospital emergency room or outpatient facility by a licensed hospital participating in the Medicaid program.

P

PA: Prior Approval.

PAID CLAIM: A claim that has resulted in the provider being reimbursed for some dollar amount. The amount may be less than the amount which the provider billed the DCH.

PAID DATE: The date that a check or EFT was generated.

PANEL: A display screen of data, defined by a title and the tagged description of the objects, such as instruction lines, data entry lines, menu areas and command lines. Each of these objects may include other objects, described in the same syntax. Panel definitions are joined in a source file to form a panel group. Objects can be shared by all panels.

PARAMETER: Any value passed to a program by the user or by another program in order to customize the program for a particular purpose. A parameter may be anything; for example, a file name, a coordinate, a range of values, a money amount or a code of some kind. Parameters may be required as in parameter-driven software or they may be optional. Parameters are often entered as a series of values following the program name when the program is loaded.

PARTIAL REFUND: Receipt received from a provider for the portion of the amount of the original claim that was paid.

PASSWORD: Confidential code used in conjunction with the User ID to gain access to a system.

PATIENT INCOME: The patient's liability income amount that must be contributed toward the cost of nursing home care by each resident.

PATIENT LIABILITY: See Patient Income above.

PAYEE: The facility or person that receives payment.

PAYMENT CYCLE: A cycle from the adjudication of claims that results in payments to providers.

PAYOUT: Non-claim specific payment to a provider or other entity (i.e.: insurance company).

PBM: Pharmacy Benefits Manager.

PEACHCARE FOR KIDS (PCK): PeachCare for Kids®. State of Georgia Children's Health Insurance Program (SCHIP). The federal-State Children's Health Insurance

Program (CHIP) was created under the Title XXI of the Social Security Act. The health benefits include primary, preventive, specialist, dental care, and vision care.

PEER REVIEW: An activity performed by a group or groups of practitioners or other providers to review the medical practices of their peers for conformance to generally accepted standards.

PENDING CLAIM: A claim that is in the adjudication process.

PER DIEM: A daily rate usually associated with payment to an institution such as a hospital or a skilled nursing facility assigned to institutional providers.

PHI: Protected Health Information. The information that needs to be protected that pertains to electronic, paper, or oral versions of information.

PHYSICIAN CLAIM: A claim filed for payment of Physician Services. A claim is filed: (1) for one or more services given on the same date, or (2) upon completion of services for a treatment. The claim is filed on CMS-1500 form.

PHYSICIAN SERVICES: Services provided by a licensed physician. Services include physician visits, laboratory and X-ray services, family planning, etc. Also included are professional services performed, certain optometry services, and eyeglasses as prescribed by a physician skilled in diseases of the eye or by an optometrist.

PI: Program Integrity Unit.

PIN: Personal Identification Number. A number used to provide a password into the system for security purposes.

PMBOK: Project Management Body of Knowledge. A guide to the current knowledge and common lexicon within the project management profession.

PM: Project Manager.

PMI: Project Management Institute.

PMO: Project Management Office.

PMP: Primary Medical Provider.

PMPM: Per Member Per Month.

POS: Point of Sale.

POS/EVS: Point of Sale/Eligibility Verification System.

PRECERTIFICATION: Hospital precertification means approval of all inpatient hospital admissions (except routine deliveries) and selected services performed in an outpatient hospital or ambulatory surgical center setting at least one week prior to the planned admission or procedure. Emergent admissions and emergent surgical procedures must be certified within 30 calendar days of admission.

PREPAYMENT REVIEW: Provider claims suspended for review prior to final adjudication.

PRIOR AUTHORIZATION: An authorization granted by the State agency to a provider to render a given service to a specific member.

PROCESSED CLAIM: A claim that has been adjudicated.

PROGRAM: Used to reference ABD, LIM, or PCK.

PROJECT ID: Field that categorizes a transaction as Regular Medicaid/Family Planning, PeachCare, Breast and Cervical Cancer, Federal less state share, Money Follows the Person, and Refugee. Also combines transaction type as determined by the type of activity and the FFP period.

PROPRIETARY SOFTWARE: Any software and associated documentation provider to the DCH and its Affiliates under this Agreement for which the Contractor or its licensors or any other third party retains any ownership rights or other Intellectual Property as authorized by 45 CFR Sect. 95.617 and for which no federal funds were used to design, develop, install or enhance such software.

PROTOCOL: In information technology, it is a set of rules describing the contents of an electronic communication. To communicate, both the sender and receiver must adhere to the protocol. See TCP/IP, HTTP, and FTP.

PROVIDER: An eligible institution, facility, agency, managed care organization, administrative service organization, person, partnership, corporation, or association as enrolled and approved by the State which accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules. Also, the renderer of a service to a member.

PROVIDER RELATIONS: Fiscal Agent employees that provide assistance to providers regarding Medicaid programs.

PROVIDER ELECTRONIC SOLUTION (PES): Proprietary Gainwell Technologies software that allows providers to submit claims from a personal computer.

PRTF: Psychiatric Residential Treatment Facility.

PURGE: Refers to moving data from the master files to the archive files.

Q

QA: Quality Assurance.

QAT: Quality Assurance Team. A multi-disciplinary team that investigates, resolves, and monitors activities performed by the FA.

QI: Qualifying Individual; a "non-Medicaid" COA that provides only for payment of the recipient's monthly Part B Medicare premium.

QMB: Qualified Medicare Beneficiary. Aged, blind or disabled individuals who have Medicare Part A (hospital) insurance, and have income less than 100 percent of the federal poverty level and limited resources. Medicaid will pay the Medicare premiums (A&B), coinsurance and deductibles only.

QUEUE DIRECTORY: A directory on a hard drive into which batch requests to unit storage are placed. (Imaging.)

R

RA: Remittance Advice.

RAD: Requirements Analysis Document.

REALTIME SYSTEM: A computer system that responds to input signals fast enough to keep an operation moving at its required speed.

REASONABLE: To use appropriate instruments or methods to bring about a desired outcome which has been dictated by this contract or by the Georgia Department of Community Health.

RECORD: A set of related fields used to enter and store information in the telephone system. A table is a set of records.

RECOUPMENT: Money withheld from a provider's payment due to overpayment of claims during adjudication cycles. Recoupments may be established online by accessing the Accounts Receivable Set Up window. They may be set up as a percentage or as a set amount to be recouped. An Accounts Receivable record is established for each recoupment type a provider might have. The taking of money from payment activity and applying against an outstanding debt owed the DCH. The activity reduces the payee 1099 balance.

REMITTANCE ADVICE: A record generated for Providers identifying payment(s) made to the Provider, the member(s) for which Medicaid made the payment(s), claims that have been entered into the system and are pending, and/or denied claims. The Remittance Advice is available hardcopy or electronic media at the discretion of the Provider.

RELATIONAL DATABASE: A database or collection of data organized into related tables comprised of rows and columns. The tables define relationships between the records.

RELEASE: The release is associated with a specific version of a product being made available to the client. Also known as system release or version.

RESOLUTION: Usually used in context as claims resolution, pending resolution, or suspense resolution. It refers to the process of working or correcting errors on a claim, forcing edits, updating or modifying inaccurate data such as a provider number or category of service, or any other activity necessary to complete the adjudication of the claim.

RESOURCE: Any real or personal property, stock, bond, or item of value owned by an individual.

REVENUE CODES: The three-digit accounting codes used on hospital claims to designate the service which generated the income, e.g., room and board = 110, laboratory pathology = 300, and physical therapy = 420. Revenue codes are used in billing both inpatient and outpatient services. These codes are essential to the hospital cost reporting process.

REVIEW: Examination and evaluation of the suitability of a particular deliverable or process.

RFP: Request for Proposals.

RTP: Return to Provider. Claims or non-claim documents that must be mailed back to the provider for additional information or clarity.

RULES BASED PROCESS: Rules Based Processing, or Table Driven System, or Parameter Based Processing are terms that refer to systems that store data element variables in user-alterable tables rather than storing them inside a fixed computer program.

RUN DATE: The date a report was generated.

RURAL HEALTH CLINIC: The RHC Program was established in 1977 to address inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. Rural Health Clinics are located in areas designated by the Bureau of Census as rural and by the Secretary of the Department of Health and Human Services or the State as medically underserved.

RURAL HEALTH CLINIC CLAIM: A claim filed for payment of Rural Health Clinic Services.

RURAL HEALTH CLINIC SERVICES: Services provided in a rural health clinic that participates in the Medicaid program. The services are reimbursed on a per clinic visit rate based on costs.

S

SAK: System Assigned Key.

SCALABILITY: The ability to manage the increases of staffing levels and of system throughput due to increased number of users, increased number of members, increased transaction volume, increased data volume and other relevant factors utilizing software and hardware modifications without impacting the performance of users.

SCAN: To convert human-readable images into bitmapped or ASCII machine-readable code. (Imaging.)

SCAN RATE: Number, measured in times per second, a scanner samples an image. (Imaging.)

SCANNER: A device that reads text, images and bar codes. Text and bar code scanners recognize printed fonts and bar codes and convert them into a digital code. Graphics scanners convert a printed image into a video image without recognizing the actual content of the text or pictures.

SCHIP: State Children's Health Insurance Program, in Georgia known as PeachCare for Kids®. The Federal-State Children's Health Insurance Program (CHIP) was created under the new Title XXI of the Social Security Act. The health benefits include primary, preventive, specialist, dental care, vision care, impatient, and restorative.

SCOA: State Chart of Accounts. General Ledger account determined based on Date of Service.

SCREEN SCRAPING: The process of capturing data from a 3270 screen session, locating the image associated with that screen, and displaying it to the user. (Imaging.)

SDX: State Data Exchange. A file created by the Social Security Administration that contains all beneficiaries who are eligible for SSI, and other data pertinent to the eligible, including termination dates and changes to information on the record.

SERVICE: A covered medical benefit under the Medicaid Program performed by a provider for a member, usually indicated by a service or treatment code.

SERVICE ORIENTED ARCHITECTURE (SOA): Represents the processes and activities needed to manage the assets of the organization in their various states. Services are detailed in an organization's information model showing what information the "Service" owns (creates, updates, and deletes) and which information it references and is owned by other "Services".

SERVICE AUTHORIZATION: See Prior Authorization.

SKILLED NURSING HOME SERVICES: Skilled nursing home services are rendered in an institution to the member. The claim relating to skilled nursing home services represents the total period of confinement, if the confinement is less than one month in duration. If the confinement is longer than one calendar month in duration, a claim may be filed each calendar month.

SLC: System Life Cycle. The Gainwell Technologies methodology for the planning, development, implementation, and support of software system projects.

SLMB: Beneficiaries that are Specified Low-Income Medicare Beneficiaries who are eligible only for payment of their Medicare Part B premiums and whose income does not exceed 120 percent of FPL.

SNF: Skilled Nursing Facility.

SNF CLAIM: A claim filed for payment of SNF Services. The claim is filed on a UB-92.

SNF SERVICES: Services provided in a licensed SNF that participates in the Medicaid Program. The per diem reimbursement is determined by cost report data and the level of care provided by the facility case mix average score derived through the submission of resident assessments received from the nursing facilities electronically in a separate subsystem.

SOAP: Simple Object Access Patrol.

Provides a way for applications to communicate with each other over the Internet, independent of platform.

SORTING: Sorting allows the user to display the retrieved data in either ascending or descending order, or in alphabetical or numerical order.

SPECIALISTS ID: A code assigned to personnel involved with processing records in the MMIS claims processing system.

SPENDDOWN: A type of Medicaid insurance deductible. The dollar amount of medical bills the beneficiary is responsible for taking care of before Medicaid can help the beneficiary pay his or her medical bills. Spenddown is the difference between the beneficiary's income and the Medicaid income limit. A qualifying county nurse may assign this dollar amount to a beneficiary (based on the beneficiary's income, etc.), which must be spent on medical needs prior to Medicaid benefits being available.

A process whereby an otherwise Medicaid-eligible person, but for excess income, may become eligible through obligation of the excess amount of incurred medical expenses. A requirement that certain beneficiaries, in order to be eligible for Medicaid, must spend money on their medical bills to offset their excess income. This is a requirement for the Medically Needy category of eligible beneficiaries. In cases of short-term spenddown, the spenddown amount is defined as being the amount that should be used for a beneficiary's provided services prior to Medicaid being involved.

SPSS: A commercial off-the-shelf statistics and data analysis software package.

SQL: System Query Language. The programming language used to access data in relational databases.

SSA: Social Security Administration. The federal agency that determines eligibility for SSI beneficiaries.

SSI: Supplemental Security Income. A federal needs-based, financial assistance program administered by SSA.

SSN: Social Security Number.

STAKEHOLDER: Party or parties that have a fiduciary interest in the Medicaid Management Information System (MMIS).

STORAGE CONFIGURATION: A drop-down list box containing these three options: Interactive, Batch, and User-Defined. (Imaging.)

SUBCONTRACTOR: Party contracting with the Contractor to perform services for the DCH of not more than 30 percent of the total scope of services required under

the contract. Entities which are subsidiaries or are otherwise owned in part or in whole by Contractor will not be considered subcontractors to the Contractor.

SURProfiler: The SUR process that provides a statistical screening tool designed primarily to identify physicians with medical resource use that is substantially different from their peers. It provides an in-depth view of utilization patterns and associated costs and allows for profiling of providers and members.

SURS: Surveillance and Utilization Review Subsystem of the MMIS.

SUSPENDED CLAIM: A claim that is taken from the processing flow for additional information, correction or review.

SYSTEM: All of the subsystems collectively and referred to as the MMIS.

SYSTEM CHANGE: A revision made to any portion of the subsystems collectively referred to as the MMIS for the purpose maintaining or improving the operation of the overall system.

SYSTEM GENERATED: Information not input from another source (e.g., a data file, data transmission or keyed by the user). Examples are date, time, calculated numbers, etc.

SYSTEM TEST: A test of all functions within a subsystem of the MMIS ensuring that all data and functions are handled correctly. In addition, the functions within the system are then tested to ensure interaction from system to system and outside the MMIS, i.e., BUY-IN, etc.

T

T-1 CONNECTION: A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.

TANF: Temporary Assistance for Needy Families.

TBQ: The Territorial Based Query (TBQ) is the CMS equivalent of the SSA BENDEX process. It is a listing of the CMS Master Beneficiary Data, and includes Medicare coverage spans, Third Party information, Medicare and SSN cross-references and other data. The primary use of this data is to establish Medicare ID and Medicare coverage dates, but the entire transaction is available for research.

TCM: Targeted Case Management.

TDD: Telecommunication Devices for the Deaf.

TFAL: Technical Functional Area Lead.

TPL: Third Party Liability. A case in which an individual, institution, corporation, or public or private agency is liable to pay all or part of the medical costs of injury, disease or disability for a Medicaid member.

TIMEOUT: A state that occurs when a response is not given within a defined time limit, for example, when a caller is prompted to enter digits and does not do so within the time period specified in the Voice System Parameters Table within the telephone system.

TITLE IV-D: Child and medical support services.

TITLE IV-E: Title of the Federal Social Security Act that authorizes financial assistance for foster children and for families receiving adoption assistance.

TITLE VI: Civil Rights.

TITLE XIX: The provisions of Title XIX of the Social Security Act, including any amendments thereto authorizing the Medicaid Program.

TITLE XXI: The Balanced Budget Act of 1997 amended Title XIX to provide each State the optional use of State child health assistance funds under Title XXI, State Children's Health Insurance Program (SCHIP) for enhanced Medicaid matching funds and expanded Medicaid eligibility for certain Medicaid groups.

TOC: Table of Contents.

TRADING PARTNER: Entity that, by HIPAA compliance standards, can share information about a member.

TRANSACTION PROCESSING: Processing transactions as they are received by the computer. Also called online or real-time systems, transaction processing means that master files are updated as soon as transactions are entered at terminals or received over communications lines.

TRANSACTION SET: A block of information in EDI, making up a business transaction or part of a business transaction.

TRANSACTION SET STANDARDS: The system of syntax, data elements, segments, and transaction sets (messages) with which EDI will be conducted.

TRANSLATOR: A program used to convert information from flat file to EDI format or from EDI format to flat file.

TRUNK: A telephone line used to make and/or receive calls within the telephone system.

TRUNK GROUP: A set of trunks used for a specific application within the telephone system. Trunk groups are defined in the Trunk Group Database Table. Trunks are assigned to both an incoming trunk group and an outgoing trunk group in the Trunks Table.

U

UAT: User Acceptance Testing.

UB-04: The National Uniform Billing 04 form will replace the UB-92. Use of this form will be required beginning May 23, 2007.

UM/QIO: Utilization Management and Quality Improvement Organization (formerly known as PRO).

UPIN: Unique Physician Identification Number.

USER: A data processing system customer.

USER ID: The code unique to an individual which allows the user to sign-on to the computer system and defines the user's security status.

V

VACCINE FOR CHILDREN (VFC): A federally funded program that provides immunization serum for qualified children.

VAN: Value-Added Network. A vendor of EDI data communications and translation services. (Switched network provider).

VPN: Virtual Private Network. Internet software for the client desktop. This allows two users to communicate via the Internet, and for security purposes, it is a closed network between the two sites. Along with this technique is "tunneling" which allows data to be sent through a private tunnel rather than over the Internet connection.

VSAM: Virtual Storage Access Method. An IBM access method for storing data, widely used in IBM mainframes.

W

WALKTHROUGH: Step-by-step review of a specification, usability feature or design conducted jointly by the DCH and Contractor**.**

WBS: Work Breakdown Structure.

WHOLESALE CHANGES: Mass changes performed by computer program that detail how to process need standards and income increases for the designated group of beneficiaries covered by Medicaid.

WINDOWS: A graphics-based windows environment from Microsoft that integrates with and interacts with DOS. It provides a desktop environment similar to the Macintosh, in which applications are displayed in re-sizable, movable windows on screen.

WITHHOLD/LIEN: The taking of money from payment activity that does not reduce the payee 1099 balance.

WORKFLOW: Automates many of the manual activities associated with task notification, timing, escalation, completion and overall control. Workflow is engaged whenever there are desk to desk activities or sequential human interaction.

Example:

Item: Written Correspondence

Details of the written correspondence are stored within CTMS

Actual process of where the written correspondence goes is Workflow

WORK PLAN: A document describing in detail the activities required to complete a specific phase of the Contract, which clearly defines necessary tasks, participants, time estimates and schedules.

WIS: Waiver Information System.

WTD: Week to Date.

X

This section has no entries.

Y

YTD: Year to Date.

Z

This section has no entries.

This page intentionally left blank.